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ANTI-BIOTIC AGENTS IN CLINICAL MEDICINE*

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MR. CHAIRMAN, Members of the Rhode Island Medical Society and Guests. In discussing anti-biotic agents in clinical medicine this afternoon, I shall confine my remarks to the use of penicillin and streptomycin.

I propose beginning my discussion with some remarks concerning the various dosage forms of penicillin that are available at the present time.

The most widely used preparation of penicillin has been amorphous penicillin, administered in aqueous solution. More recently, crystalline penicillin G, either the sodium or potassium salt, has been generally available. This preparation is most popular for the reason that it contains one of the most active penicillins, and it is the only penicillin available in crystalline form for clinical use.

There is no choice between the use of either the potassium or sodium salts of crystalline penicillin G, as they are both active biologically, and they are both stable, without refrigeration.

Another preparation that has had wide use is the one developed by Dr. Romansky and his associates, namely, penicillin in oil and beeswax. The purpose of this preparation is to delay the absorption of penicillin from local deposits in the muscles. The first preparation to be developed was amorphous calcium penicillin, in peanut oil and beeswax.

Crystalline penicillin G, suspended in oil and dispersed in wax, is now available for clinical use. It has been found that a single injection of one cubic centimeter of this preparation containing 300,000 units per c.c will provide assayable blood levels, in most patients, for a period of twenty-four hours. If 600,000 units are given in a single injection, it is found that in all patients there will be assayable blood levels throughout the twenty-four hours. Or, if one divides the total dose of 600,000 units daily in halves and gives 300,000 units every twelve hours, one can be certain that there will be assayable blood levels throughout the twenty-four hour period.

Oral preparations of penicillin have been widely used. These preparations have been limited somewhat by their excessive cost. It is known that it requires at least three to five times as much penicillin when it is administered by mouth, as when it is given parenterally, in order to obtain comparable clinical results or comparable blood levels.

It is well to say then that 300,000 units of penicillin a day in oil and wax will usually be adequate for the treatment of most infections. If two injections are given daily at 12 hourly intervals, then one can be certain that all patients will have assayable blood levels for a period of 24 hours.

In using oral penicillin, the one thing to remember is that at least three to five times as much penicillin should be used as is generally employed by the parenteral route.

With respect to dosage, there is no rule about dosage of penicillin in any given infection. The reason for this statement is that different organisms vary so widely in their sensitivity to the action of penicillin. When you consider that most patients with gonorrhea are cured within a period of fifteen hours, following the use of 100,000 to 150,000 units total dosage, and it often requires six to eight weeks using half a million units a day to cure patients with subacute bacterial endocar-

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ditis, you can appreciate the wide range of dosage that is needed for the treatment of various infections.

The best rule to follow, once the type of infection is known, is to give that amount that will bring the infection under control in the shortage period of time.

One other subject that is often discussed is the question of bacterial resistance to penicillin. Fortunately, this is a problem that has not given us very much concern, for the reason that it plays little or no part in explaining penicillin failures. It is true that you can make micro-organisms more resistant by multiple dosages, but that plays very little role in clinical infections. There are some strains of hemolytic staphylococcus aureus that are resistant from the beginning, so that very large amounts of penicillin will not destroy the organisms. But, the development of acquired resistance has been of little or no importance in explaining penicillin failures.

The results of the use of penicillin in most infections are well known to you. But, to repeat, one can say that penicillin continues to be the drug of choice in all staphylococcal infections, in all pneumococcal infections, in hemolytic streptococcal infections, and in gonorrhea and syphilis the two most prevalent venereal diseases, and subacute bacterial endocarditis, due to non-hemolytic streptococcus.

Following the use of amorphous penicillin, the degree of hypersensitivity that develops in different patients varies between three and five per cent. That is to say, between three and five per cent of all patients who receive penicillin for a period of seven to ten days become sensitized to it, and develop urticaria.

There has been a general impression that the incidence of hypersensitivity is higher among those receiving peanut oil and beeswax. Statistical studies bear this out only in part. When alternate cases are studied with crystalline G in aqueous solution and crystalline penicillin G in peanut oil and beeswax the incidence of sensitivity was approximately three per cent for aqueous and five per cent for peanut oil in beeswax.

When peanut oil and beeswax are used, somewhat higher incidence of hypersensitivity may be observed.

The urticaria accompanying hypersensitivity is readily controlled in most instances by the use of benadryl or pyribenzamine. These drugs are of value in the treatment of the urticaria.

With respect to streptomycin, the only dosage forms that have been available are the chloride, the sulfate, and phosphate salts. Streptomycin has the characteristics of an organic base, and it can be combined with chloride or sulfate or phosphate. In our experience, there is no choice between the different salts. They are all equally effective. They are all equally soluble, and they are absorbed with the same rapidity from deposits in muscles.

The intramuscular route is the one of choice since very little streptomycin is absorbed from the gastrointestinal tract. It is absorbed in such small amounts that it would be of no practical use in the treatment of systemic infections.

The dosage schedules in streptomycin have varied, depending upon the type of infection. The smallest amounts have been found necessary in patients with tularemia. That is a disease of no great importance in New England, but in the United States there are approximately 20,000 cases a year, with a total fatality rate of seven per cent. In the pulmonary form, however, the fatality rate is as high as forty per cent. In this disease then, only one half or one gram a day, for five to seven days, proves to be adequate. Most patients with urinary tract infections will require from one to two grams daily for five to seven days. If the urine of the patient is not sterilized within a period of seventy-two hours, one is usually dealing with a resistant organism, or some complicating factor, such as a foreign body in the genito-urinary tract or an undrained abscess.

In patients who have tuberculosis, the usual dosage schedule has been much larger; namely, between two and three grams a day for a period varying between two and three months. The problem of the treatment of infections with streptomycin is somewhat different from that of penicillin, for the reason that most organisms that are susceptible to streptomycin have a much greater tendency to become resistant or to develop resistance during the course of exposure to streptomycin. In fact, Dr. C. Philip Miller has recently shown that at least one variant of the meningococcus requires streptomycin for its growth; with this variant streptomycin becomes an essential growth factor for the meningococcus. So far, no other bacterial species have been found in which streptomycin is required for the growth of the organism.

The problem of increased resistance of gram negative bacilli to streptomycin is a very real one, and explains, in many instances, streptomycin failures.

Another stumbling block in the use of streptomycin has been the side effects that have occurred following its use for periods longer than seven to ten days. You will find that a certain number of patients develop hypersensitivity reactions, urticaria, fever, etc., and they are not very serious, in that they do not produce any permanent damage or destruction of tissues. The most serious side effect, of course, has been the vertigo that occurs in varying frequency, depending upon the time-

dose relationship. In most patients who receive streptomycin for periods varying between two and three months, in amounts of one 1½ to 3 grams a day, vertigo will develop between the seventeenth and the thirtieth day. This comes on suddenly, is often very disturbing to the patients, and is very severe.

In general, most of these patients learn to compensate for the vertigo, so that after a period of thirty, sixty or ninety days, all symptoms and signs of vertigo may disappear, and no damage can be detected, unless tests for labrynthine function are carried out. In many instances, however, the decrease in this function has persisted for as long as a year, or for as long as many of the patients have been followed. If you give streptomycin for a long period of time, that is, for over a month, to patients with tuberculosis, for instance, you can expect to find that most of the individuals will develop vertigo. If it is given for a period of five to seven or ten days, then only about five per cent of the patients will develop vertigo.

Deafness has been reported under three circumstances,—in patients with meningitis, who received large amounts of streptomycin intrathecally, and in those who received excessively large amounts of streptomycin systemically six to ten grams a day, with the expectation that the disseminated tuberculosis might be brought under control.

Finally, there is a group of patients who have received relatively large amounts of streptomycin, in the presence of renal insufficiency, who have become deaf.

Deafness may be observed, then, in patients under the conditions I have mentioned, and it is something to be looked for in that particular group of patients.

With respect to the results that have followed the use of streptomycin, I think it is fair to say that this antibiotic has taken its place, along with penicillin, in controlling a large number of infections that were not controlled in the past by the use of the sulfonamides or penicillin. The outstanding results have been obtained, first of all, in tularemia, secondly, in urinary tract infections, and third, in *Hemophilus influenzae* meningitis.

In our own experience at the Haynes Memorial in Boston, we have had twenty recoveries, out of the last twenty-one cases of *Hemophilus influenzae* meningitis, using streptomycin alone, given by the intramuscular and the intrathecal route.

In patients who have bacteremia due to gram negative bacilli, one often finds that the fatality rate in this group is greatly reduced, and that recovery occurs much more often now than it did in the past.

The overall fatality rate in that group of cases is now approximately twenty-five per cent, whereas it was formerly in the neighborhood of seventy per cent.

At the moment, extensive studies are being carried forward by many groups, such as the Veterans' Administration, the Army, the Navy, to determine the place of streptomycin in tuberculosis. It will require a much longer period of observation before we can make any statements as to the position of streptomycin in treating tuberculosis. Up to the moment, we can say that it is the only chemotherapeutic agent available that can be given to patients with tuberculosis that will influence favorably the course in a number of instances.

In patients with pulmonary tuberculosis, with predominantly exudative lesions, it is quite striking to see these exudates disappear in a relatively short period of time, but what is more impressive in many instances is the striking change in the clinical appearance of the patients. Frequently, the temperature returns to normal, the cough lessens, the appetite improves, and these patients improve subjectively as well as objectively in a relatively short period of time.

The results in tuberculosis of the meninges have not been very outstanding, except for the fact that a number of patients with tuberculous meningitis are now recovering. They don't all recover permanently; they have some damage to the central nervous sytem. But, for any patient with tuberculous meningitis to recover following the use of a chemotherapeutic agent is certainly a step forward.

In the treatment of tuberculous sinuses, and tuberculosis of the larynx, the results have been quite striking, and one can observe these sinuses to close and the ulcers in the larynx and the trachea to heal promptly within a period of four to six weeks.

There is very little information concerning its use in bone and joint tuberculosis, or even in renal tuberculosis. The results reported so far in renal tuberculosis indicate that it is a palliative measure, that the amount of pyuria diminishes, the number of organisms decrease and the capacity of the bladder often increases. The dysuria is frequently alleviated.

One can sum up the results in tuberculosis by saying that we do not know the exact position of this drug in the treatment of this disease, but that it is the only chemotherapeutic agent available at the moment that tends to inhibit the growth of the tubercle bacillus and produce positive effects.

In summary, then, I think one can say that with the use of these two agents, penicillin and streptomycin, we have all observed perfectly extraordinary changes in the course of many infectious diseases, and this is something that few of us dreamed of, even as short a period of time as five years ago.

PSYCHIATRIC LESSONS LEARNED IN THE ARMY*

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It is a very real pleasure and an honor to have been invited to speak at this 136th Annual Meeting of the Rhode Island State Medical Society on some of the psychiatric lessons learned in the last great war. I believe that it is altogether fitting and proper that a portion of this meeting should be devoted to the subject of mental ill health. Our experience in this war has reaffirmed some medical facts which too few of us were aware of in peacetime. Not all of us realized that over half of the hospital beds in the United States were devoted to the care of the mentally ill. If we stop to think we would agree that from 50 to 60% of the patients crowding physicians' offices come because of complaints that are not founded on an organic basis. Rather their illnesses are based on emotional factors. The last great struggle in which our country was engaged brought these facts out in bold and dramatic relief. Without a question psychiatric disturbances presented a great, if not one of the greatest problems to be faced by the Medical Department of the Army. Similarly the post war period is presenting to the medical profession an equally large psychiatric problem.

Inasmuch as there were insufficient psychiatrists, many of you who were in the Military Service, and whose pre-war interests were other than psychiatry, found yourselves assigned many times to psychiatric duty. For better or for worse, the general public has become much interested in psychiatric matters. There have been psychiatric novels, psychiatric movies, books have been written on psychiatry for the layman, newspaper columns have given the subject much space; in short, psychiatry has been receiving an increasing amount of publicity in the past few years, as a result of which the public is much less afraid of the stigma that heretofore existed in relation to emotional illness. The public expects therefore that every doctor will have some knowledge of psychiatry.

The relatively short time at my disposal will not permit me to discuss much more than the size of the problem and the lessons learned from our experience in the Army. There is no doubt among any of us about the remarkable accomplishment of psychiatry in the Army considering the size of the problem with which we dealt, and of the lessons learned. The success of the program was in a large measure contributed to by many physicians who did not have previous psychiatric training.

The places where psychiatrists or physicians assigned to psychiatry served in the Army were numerous. They functioned as members of the Staff in practically every conceivable type of Army medical organization. They were found at the induction centers, they served in many of the 65 regional hospitals, and in many of the 306 station hospitals in this country; in the 217 general hospitals, 196 station and 91 evacuation hospitals overseas. There were 10 specialized hospitals devoted entirely to neuropsychiatry, 8 overseas and 2 in this country. Five of these hospitals were primarily for neurotic patients and three for psychotic patients. One of the greatest opportunities for psychiatric service, particularly in the field of prevention was in the out-patient unit called the "Mental Hygiene Consultation Service". There were 36 of these units established in basic training camps throughout this country where the new soldier who required help, was aided in making a satisfactory adjustment to army life. Psychiatrists were also placed in disciplinary barracks and in centers of rehabilitation and military prisons. The 23 convalescent hospitals were developed largely to meet the needs for more adequate treatment facilities for neurotic patients, who numbered from 30 to 50% of the patient load in these installations. Psychiatrists served in each of the 99 combat divisions. In addition they served in redistribution and separation centers.

The Size of the Problem

Statistics can only roughly describe the magnitude of the neuropsychiatric problem in the Army. They do not indicate the obstacles, the dis-

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appointments, the frustrations or the satisfactions, devotion to duty or the caliber of professional work. They do not reveal the large number of minor mental upsets which never came to the attention of the psychiatrist just as is the case in civilian life. Statistics depend upon diagnoses, and on this point there was considerable confusion within military medical circles which required close study of the situation. The result was the publication of a new nomenclature by the Army which was intended to clarify the situation further. Then too, one could be quite suspicious that some psychiatric diagnoses were made for purposes of convenience. Orders were repeatedly issued to the effect that a diagnosis should not be made in order to expedite the final disposition of a case, but rather diagnoses had to be based on accepted standards. Therefore, when one considers military statistics, one must keep these points in mind.

The latest available figures are essentially those presented by General Menninger who was Chief Consultant in Neuropsychiatry during World War II, at the last meeting of the Psychiatric Association.[1] He states that during the period of Jan. 1, 1942, through Dec. 30, 1945, approximately 1,850,000 men were rejected for military service because of neuropsychiatric disorders. These figures represented 12% of all the men examined and 38% of the men rejected for all causes. From Jan. 1, 1942, to Dec. 30, 1945, there were approximately 1,000,000 patients with neuropsychiatric disorders admitted to Army hospitals. This resulted in a rate of 45 admissions per thousand troups per year and constituted 6% of admissions for all causes to all the hospitals. Less than 7% of these admissions were psychoses; 63% were psychoneuroses and the remaining 30% represented diagnoses of psychopathic personality, mental deficiency and other psychiatric or neurological disorders. Of the million admissions for neuropsychiatric conditions, 40% were among soldiers overseas, and 60% among soldiers on duty in this country. The peak load of psychiatric patients occurred in the month of April, 1945, when there were approximately 50,000 neuropsychiatric patients in our Army hospitals at that time. 380,000 men were discharged from the Army during this same period with medical discharges because of neuropsychiatric disorders. This represented 39% of all medical discharges. In addition to this large number, 163,000 men were discharged administratively for personality disorders which included mental deficiency, psychopathic personality, enuresis and other conditions, which according to Army regulations were not given medical discharges. This made a total of over 500,000 men discharged for personality disorders.

The evacuation figures are also significant during this period from 1942 to 1945. Nearly 19% of the number of the patients evacuated from overseas hospitals were neuropsychiatric. This figure broken down shows that 31% of the patients who were returned in 1942 for medical reasons were psychiatric and following the great increase of battle wounded this fell to 15% in 1945.

The Lessons Learned in Military Psychiatry

Many of the lessons learned in this last emergency had to be relearned from World War I. Many of the difficulties which faced us and which we were obliged to grapple with were clearly outlined in the Medical History[2] of the last war. If the military service during peacetime had kept the lessons learned in the last war more completely in mind, much of the difficulty which we encountered would have been overcome. It is incorrect to believe however, that the military is alone at fault. Organized psychiatry certainly deserves much of the blame. During the peace years no attention whatever was given to the problems of military psychiatry. So that this will not happen again, many of us who were in the military service and who are members of the American Psychiatric Association have banded together in a special Section of the organization. It is the purpose of the Section to keep the lessons learned alive, and to make further plans.

Of course, many new lessons were learned, since this war differed markedly from the last. The fighting itself was far more furious and mobile. It was fought in all climates from the Arctic to the Tropics. It is difficult to place priorities of importance on what we have learned. General Menninger talked of the army as a great human laboratory. It provided a controlled situation in which all men were regimented and lived under the same conditions and presumably all were motivated toward a common goal.

One lesson that we did learn was the widespread misconception regarding the whole subject of mental health in the mind not only of military personnel but of the civilian public, the family back home and the public press. It is generally recognized that the concepts of physical health cover a wide range of conditions, ranging for example, from a light head cold on down to terminal lobar pneumonia. Mental health on the other hand has been regarded as either black or white. Either a man was insane or he was completely normal. The possibility has not been considered that there might be anything in between. Actually, of course, mental health, just as physical health, ranges all the way from good to bad. A man may have a minor temporary mental ill-health just as he may have a head

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cold. Mental disorders may be acute or chronic, severe or mild.

A great deal of confusion arose on the basis of terminology and semantics. Any word beginning with the letters "psy" to the average mind suggested something mysterious and alarming, such as insanity, perversion, or homicidal tendencies. Many laymen become frightened and resentful when a psychiatrist applied a medical term to conditions they were used to recognizing as "a case of the jitters" or "gone stale" or "nervousness". It was difficult for the ordinary person to realize that when a case of the jitters became sufficiently serious to incapacitate a man or to produce insomnia and indigestion, a psychiatrist might call it psychoneurosis and yet not mean anything more serious than was meant by the layman who called it the jitters.

A lesson which we learned early in the war was that psychiatric screening in the induction station, although important, was only the first step in preventing psychiatric casualties. It was not to be concluded that the screening process was useless or that, if screening had not been in effect, the number of cases developing in the Army would not have been still greater. Mental defectives, severe psychopaths, psychoneurotics and psychotics were still ineffective as soldiers and could not be used in the Army. The point was, however, that this group of individuals comprised but a small fraction of the neuro-psychiatric cases being encountered. The vast majority were cases of psychoneurosis. They constituted almost all of the neuropsychiatric cases occurring in combat and most of those returning from overseas. Similarly, the greater part of the neuropsychiatric cases admitted to hospitals in the continental United States and the greater part of those discharged from the Army were psychoneuroses. Furthermore, considerable evidence accumulated which indicated that a large portion of these cases were occurring in individuals whose past history was negative for neuropathic traits or anything that could be taken to indicate predisposition to psychiatric disorders. The myth that only weaklings developed psychiatric disturbances was finally exploded completely by early reports from combat theaters where the problem was carefully studied. It was found in one campaign that the incidence of psychiatric cases was uniformly higher among veteran combat troops than among fresh green troops. Months of intensive combat had weeded out all of the weaklings and the men who remained had proved the toughness of their underlying personality structure by their mere survival. Yet fatigue and other factors produced more "psychoneurotics" in this group than among fresh, untrained troops. In short, it became evident that anybody could develop a psychoneurosis under certain circumstances particularly if sufficient stress was applied. The limitations of screening became obvious. It could not be expected to have any effect whatsoever on decreasing the rate at which "normal" men broke down. It further ran the risk of eliminating men who, although having some defect of the personality, nevertheless, if properly handled, could render valuable service in the Army. Extensive studies were made both of troops successful in training and of troops who had gone through intensive combat without developing psychiatric disorders. The results, although they corroborated the general impression that the incidence of neuropathic traits was higher among men that had broken down than those who had not, nevertheless, showed that there were a great number of men successfully making the grade and doing good jobs who admitted to having many of the signs and symptoms ordinarily taken to indicate weakness of the personality. For instance, among soldiers on duty in the continental United States, a significant percentage admitted nail biting; said they had sick headaches; had been bothered by nightmares; by "upset stomachs"; by nervousness; by frequent insomnia; by dizzy spells; and by frequent palpitation. It is very probable that the incidence of these same signs and symptoms are considerably higher among so-called "normal" civilians. This impression should teach us that in our civilian practice we should not pay too much attention to individual symptoms but rather to the entire personality and its adjustment to every day life.

Another very important and impressive experience of military psychiatrists was the recognition of the importance of external stress in precipitating personality disorders. The existence of psychiatric determinants as such, the history of maladjustment in the family or the individual, did account for many of the casualties. On the other hand, far more impressive was the power of factors in the environment which supported or broke the individual. We learned early that the maintenance of mental health was largely a function of leadership and included the extremely important element of motivating the soldier to do his proper part, and closely identifying with his associates and unit. The absence or weakness of any of these factors in the presence of many excessive stresses seemed to account for a large number of psychiatric casualties. The same factors are applicable in civil life. Each person desires security and needs to feel that he is a member of the community and all that implies.

It is well recognized that there are few, if any, situations in civilian existence comparable to military life. The separation from home and loved ones and comparative freedom had to be given up for regimentation, discipline, lack of freedom and

the physical stress of training. This was sufficient to produce breakdowns in many individuals. For those who survived the training period there was the prospect of shipment overseas through dangerous waters to the far corners of the world, living in extremes of climate, being exposed to constant danger, with few of the comforts and luxuries of everyday home life. Should the individual survive all these, he was then faced with the supreme test of surviving the ordeal of combat, which certainly has no counterpart in civilian life.

It may be surprising to many of you to discover that only 7% of the hospitalized psychiatric patients were psychotic. Early in the military emergency the Army made provision for many times that number of psychotic patients. As a matter of fact as late as 1941 the Army thought of psychiatry largely in terms of disposition of psychotics. It was not until sometime later that treatment was organized in the Army and provisions made for the large number of psychoneurotic patients which appeared. All of this in spite of the fact that Colonel Thomas W. Salmon[3], Chief of Neuropsychiatry in World War I reported, "psychiatry has concerned itself almost exclusively with insanity. Today that term is properly applied to only a relatively small proportion of all persons in whom psychiatrists are interested."

Another lesson learned was that the teaching of psychiatry in medical schools fell far short of its objective. Many medical officers were inadequately equipped even in the rudiments of psychiatric understanding and treatment. What is perhaps even more important and serious was that few had any interest in psychiatric matters and many openly boasted proudly that they knew nothing about them and did not want to have anything to do with them; all this in spite of the fact that the psychiatric problem was one of the greatest that the Medical Department had to face.

There was a very great shortage of trained personnel, not only of psychiatrists and neurologists, but of psychologists and psychiatric social workers. Of the 2400 medical officers assigned to neuropsychiatric duty, only approximately 800 had psychiatric experience prior to the war. The remaining number were trained in the Army and most of them attended an intensive three-months' course in neuropsychiatry before assignment. Much to our surprise this group did a splendid job. We also had to provide training for clinical psychologists, and we had to train individuals in the A.B.C.'s of psychiatric social work. Not until after the war was over did we have anywhere near enough trained personnel to do the job. In many instances the Neuropsychiatric Service of a hospital comprised more than half of the entire Medical Service in that hospital. To handle these large numbers, less than 3 to 5% of the physicians were assigned to psychiatry. As General Menninger[4] has stated "We offer no apologies for our personnel though we are frank in the admission that many of them were inadequate personally and professionally, including many of those who had had prewar experience in psychiatry."

Once our treatment program got well under way, it was evident that when extensive early treatment was provided in an atmosphere of expectation of recovery, remarkable results were obtained. Even with stream-lined treatment methods, a remarkable recovery rate occurred. This was true in combat areas where 60% were returned to duty within a few days, and an additional 30% within a few weeks. In our hospitals in this country, which received only the most resistant cases from overseas, it was possible to return an additional 15 to 25% of combat casualties to some kind of duty and to send the great majority of the others home much improved. Remarkable results were observed in the recovery rate of psychotic patients who so often become custodial patients in civilian hospitals. Possibly because of early recognition, partly because of intensified treatment, seven of each ten psychotic hospital admissions in 1945 were able to be discharged to their homes. Of one million neuropsychiatric hospital admissions there were only 380,000 men discharged from the Army. Many of these were hospitalized prior to 1944 when the treatment program was officially approved for psychiatric patients in the Army. This naturally leads one to the conclusion that if we could educate the public, if we could adequately staff our clinics and hospitals, and if, above all else, we could emphasize and practice intensive early treatment, we could revolutionize the rate of recovery of mental illness.

Throughout military experience we discovered the undeniable fact that leadership was of great importance in the preservation of mental health. With good leadership, a soldier had the inspiration of emotional attachment to his superior officer, and this attachment was most important in order to accomplish the mission of the unit. We seemed to learn anew the importance of group ties in the maintenance of mental health.

We were greatly impressed by the fact that an individual who had a strong conviction about his military service and realized the reasons why he was in the military service, even though he was of unstable personality, might make a remarkable achievement against the greatest stress. We saw again and again the relationship between how people feel and believe, and think, and the resulting mental incapacity.

We early learned another lesson, and that was the great social need for psychiatry. There was a

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great need for the application of its principles to many activities which were not directly concerned with diagnosis and treatment of illness. We saw the need for the use of psychiatric principles in selection. Although we never accomplished it in the American Army, we felt that psychiatric study should be a cornerstone in the selection of officers as it became in the British Army. We could see that psychiatry could make a great contribution to the solution of the problem of getting the right person in the right job. We saw the results of misassignment which in so many instances directly contributed to the development of a psychiatric casualty. We had extensive training in its application to penology and realized that further definite contributions could be made in that field.

Another lesson learned was that in the majority of cases long and expensive treatment was not necessary. Because there was so few psychiatrists and so many patients, short cuts in treatment had to be developed. This was the only way of saving time for the psychiatrist so that he could have contact with more patients. The development of group psychotherapy and the extensive use of hypnoanalysis and intravenous abreaction adequately demonstrated that such methods were feasible. No longer was it necessary for a psychiatrist to see and treat only six to eight patients a day, since much time and effort could be saved through the use of these new methods, thereby allowing more patients to have the benefit of treatment.

Those of us who struggled with the immense psychiatric problem had the feeling that much could have been accomplished in the field of prevention. The surface of this problem has hardly been scratched. We had every reason to believe that had we had the manpower to devote the necessary effort and time to the preventive aspects of psychiatry, such as was given to the preventive efforts of internal medicine, we too could have perhaps demonstrated spectacular achievements comparable to vaccination or D.D.T.

In conclusion, we felt that psychiatry in the Army did a reasonably creditable job, primarily because of the devotion, integrity and ability of a handful of men and women. It goes without saying, however, that organized medicine and its members have a wide challenge confronting them in the community. The medical profession must take a more active interest in emotional disorders. It will not be sufficient to say to the emotionally ill "you are only nervous, there is nothing wrong with you, all you need is a rest". Such an attitude will drive them to become victims of quacks and charlatans. The proportion of individuals coming to doctors for emotional disorders is very high. The medical profession must take on the attitude of the student, that is, the willingness to learn in order to help these people. There are not enough psychiatrists available, neither should it be necessary for patients with mild emotional disorders to be referred to a psychiatrist. They expect to be, and should be treated by physicians in general practice.

In the field of psychiatry, as in any other field of medicine, prevention is of primary importance. Certainly no other medical person has access to so many homes in such a variety of situations as the general practitioners. No other person has such an opportunity to recognize early signs of mental disorder. Early treatment is tantamount to early recovery. Here much can be accomplished in helping to dispel the popular misunderstanding and misconceptions concerning mental ill health. Families often dismiss mental upsets in their members as mere nervousness. They feel that such conditions are a disgrace, that they are effective only temporarily, and at the same time they believe that time will solve the problem. The physician's counsel is of great value to the family whose thinking has become so subjective that a clear conception of the best procedure to adopt for its ill member is impossible.

Your organization must join with the psychiatric organization to consider this great problem. We must not let these lessons be forgotten. We can agree with General Menninger[5] when he said "we can not become too complacent or too smug to follow up on these challenges. Our best hope lies in the cohesion of our forces in a plan of strategy, a conviction as to the importance of the job and a militant leadership."

But we as individuals also have responsibilities. If we can only use our influence for the benefit of peace time mental health, another lesson will have been learned. More realistic thinking during the past two decades should have prevented many of our young men's maladjustments in the Military Service.

We failed to imbue in many the fervors and convictions that would enable them to withstand the rigors and unpleasantness of military life. Too long, we stressed the rights and safety of the individual, at the same time giving little thought to the rights and security of the group. Our country found itself ill prepared for war, and our citizen soldiers even less prepared mentally for the struggle. We asked our young men to submerge their individualities in mass team work. Small wonder that some of the players in the grim game had to drop out.

We and they paid heavily for twenty years of wishful thinking. Let us not make that mistake again.

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TRENDS IN PART-TIME INDUSTRIAL HEALTH SERVICE*

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THE SUBJECT "Trends in Part-Time Industrial Health Service" was selected for discussion for the reason that a majority of industrial physicians are employed on part-time bases, and are supplying the types of medical services available to a large majority of industrial workers. The problems confronting part-time physicians are more complex than those usually experienced by full-time physicians, even though the scope of the programs they engage in differ, theoretically, in extent rather than quality.

There probably is not a branch of medicine which is undergoing more drastic changes today than industrial medicine and, I might add, there also probably is no branch of the profession offering greater opportunities for improvement. This opinion is expressed notwithstanding the fact that many plant health services, part-time as well as full-time, are providing thousands of industrial workers with efficient health care. The fact still remains, however, that, in so far as attitude and support by industry and labor are concerned, there still is too much prejudice, lack of appreciation of good health services and general unconcern. Such opinions are due, in some instances, to lack of opportunity to see a good medical program at work. There still are too many inadequate services in industry which, not only are not worthy of wholesome support by management and employees, but which also are barriers to the progress of good medicine both in and out of industry.

Historical Review

Industrial medicine is one of the newest branches of medicine. There were a few isolated examples prior to 1900 but, generally speaking, industrial medicine really came into existence following the passage of Workmen's Compensation laws in the various states. These laws forced management to provide medical care for industrial cases, and it soon became evident that it was cheaper to bring the doctor to the cases than to send the cases to him.

Industrial medicine got its start in a majority of plants through compulsion. The doctor was employed because the law required it and the attitude was to have him take care of accident cases and do nothing else.

The plant official often selected his own family physician or went out in the open market, so to speak, and shopped for a cheap one. In either case, the physician often had no specific knowledge of industrial medical problems and had little interest in anything except the treatment of the injured workers. Such physicians previously had "pro-industry" attitudes or they soon developed them. Their duties, as they saw them, were to take care of the company's interests, and this they usually did, without too much consideration being given to the fact that what actually was to the best interest of the company also was to the best interest of the workers and the medical profession as well. Some of these physicians also became "pro-Insurance Company" in their attitudes, thus further widening the breach between industry and the workers on the question of industrial medicine.

All of these adverse conditions also had their effect upon the attitude of the medical profession. Many early plant physicians were judged harshly by their colleagues because they were willing to stoop low enough to become "plant doctors," or even to accept "insurance cases" in their private practices.

These and many other factors seriously handicapped industrial medicine at the outset and their retarding influences have not yet been entirely eliminated. There was another side to the early picture, however, which cannot be overlooked because it is to it that we owe the credit for all the good qualities of industrial medicine.

Some plants had the correct attitude toward employee health even before the passage of compensation insurance laws. Others soon were able to see that they could effectively promote good employee relations by providing competent medical service and, at the same time, make the investment pay substantial dividends by improving employee health through preventive medicine.

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* Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 15, 1947.

Such organizations procured physicians who were competent in attitude and perspective as well as in the practice of medicine. The physicians were not "pro-industry," or "pro-labor." Their conduct seldom was challenged and they had the support of both management and the employees.

The scope of service rendered by these earlier doctors naturally was not as comprehensive as it is today. Some of them specialized in surgery, others in general medicine or in some special phase of medicine. In doing so, they may have neglected certain problems because of insufficient knowledge or interest. Yet, when we look upon the accomplishments in a collective sense we realize that the sum total of all these individual efforts, both generalized and specialized, set the standards of good industrial medicine for succeeding generations of industrial physicians to follow and improve.

Present Day Attitudes Toward Industrial Medicine

The present day attitude of industry toward industrial medicine is based upon past experiences. If industry is seeking the assistance of the medical profession in the extension and improvement of plant health programs, the sign is good. If, on the other hand, the average plant still is content to use doctors to the least extent permitted by law, the reason probably is due to lack of knowledge concerning the advantages of a modern plant health program.

The attitude of employees is a very reliable indication of the quality of medical service they are receiving. If they utilize and respect the services provided by their employer, even in states where they have free choice, this speaks very well for the medical program. If, on the other hand, a majority consider the doctor as a "quack," a "butcher" or an unfair "company doctor," they probably are correct.

The attitude of the medical profession as a whole toward industrial medicine also is highly significant. Many medical societies are demonstrating the same type of good faith which your organization is displaying by actively promoting better plant health programs. This type of support is essential. With it, the industrial physicians can go a long way but without it, they are faced with very serious handicaps.

The average plant today is receptive to any practical suggestions which will be for the improvement of industrial health standards. Management has learned that good health and good employee relations are closely related and that without them, production suffers. Yet, industry still presents a frontier to industrial medicine which has been only partially developed. The extent to which this territory is opened up rests largely in the hands of the medical profession. There already are enough potential purchasers of modern plant health programs to seriously tax the abiliities of most medical groups to deliver. This degree of receptiveness is proof enough that whatever the earlier handicaps were like, industrial medicine is now out in front.

Further evidence of this progress is to be found in the interest which The American Medical Association and the various state and local societies are taking. Your own efforts are an example of what is going on throughout the country. This interest is being expressed along two basic lines. Considerable emphasis is being placed upon the study of medical problems peculiar to industry. Medical schools are offering undergraduate and postgraduate courses in increasing numbers. Seminars, clinics and special conferences are common today but they were rare as recently as ten years ago. The medical profession as a whole, and many individual physicians, are at last definitely convinced that however skillful or successful a physician might be in dealing with general health problems common to the community, he might be a failure, in handling industrial cases. The fact has been demonstrated that industrial medicine and general medicine are not necessarily one and the same, but that success in the plant practice can be measured by the special knowledge the physician has of medical problems peculiar to the plant.

The other basic approach of the medical profession toward the improvement and extension of industrial medicine deals with the consumer. Lay information, graduated for both industrial officials and workers, is being disseminated in various ways. One of the most interesting recent approaches along this line is the cooperation given by the profession in the organization of demonstration services. The objective here is to assist a group of small plants in employing part-time medical and nursing care under a plan of joint guidance until the merits of a modern health program have been demonstrated. The idea from here on is for the plants to provide on a continuous basis whatever amount of such services their problems and size merit.

Through such demonstrations, the employees are given an opportunity to sample the benefits of a progressive preventive medicine program which adds to, rather than stints, basic medical care to which they are entitled by law.

These demonstrations unfortunately are quite late. Had it been possible to do more educational work along this line during the earliest days of industrial medicine, many mistakes would have been

avoided. Both industry and labor would have learned early what many of them are just now learning, namely, that a plant health program voluntarily dedicated to the prevention, as well as treatment, of job-connected disorders can be far more beneficial than one conceived through compulsion and confined to the minimum services required by law.

Another favorable sign is the extent to which physicians are going into industrial practice. They are turning toward industry in greater numbers than ever before. Some are undoubtedly interested solely as a temporary security measure until they become established in other branches of the profession. Others simply are looking for easy jobs and do not realize what is involved in the practice of modern industrial medicine. It is undoubtedly true, however, that a very substantial number are interested in industrial medicine as careers and they will become valuable assets to the profession.

Trends in Industrial Medical Services

As to the scope of future plant health programs, there also are many favorable signs. Some of them have been referred to already in this discussion, others are just now putting in their appearance, and cannot be too clearly analyzed at the moment. It does appear evident, however, that all signs point toward the rounding out of services which will strike proper balances between therapy and prevention. Some individual programs still are top-heavy in one direction or the other and, in some instances, too much time is being wasted on fads or relatively unimportant problems. It is my opinion that the most significant trends are concerned with the improvement of services which have been recognized as within the province of industrial medicine for a long time. Consequently, I should like to discuss a few of them briefly at this point.

Treatment

The treatment of job-connected disorders still is the fundamental function of the plant medical department. This function will maintain its present importance until a much better job is done in preventing industrial disabilities. Along with the improvements in techniques and skills of rendering this service, plant physicians are devoting more attention to the physical, physiological and psychological circumstances of the individual in relation to the environmental factors which cause or contribute to injuries and illness.

The earlier tendencies in some plants of handling industrial cases on an impersonal basis are disappearing. Industry is becoming increasingly aware of the fact that medicine, in as well as out of industry, is only good to the degree that its eventual application is based upon proper consideration of the individual. This newer appreciation of the value of good medical and surgical care is based upon a growing conviction that management's best interests are thus served. Many labor relations problems in industry grow out of poor and discourteous handling of cases. The ultimate effects of such disorders may be far reaching. Good conduct on the part of the medical staff may result in the elimination of such industrial problems.

So, the trend in so far as treatment of cases is concerned is to provide adequate therapeutic care. Whether the case is handled in the first-aid station, nursing station, plant hospital, or by consultants, does not alter the importance of making every effort to constantly improve the quality of care given. Just as many first-aiders have given way to registered nurses, so have many incompetent physicians been replaced by good ones.

Physical Evaluations

Physical examinations, functional capacities evaluations and proper placement of handicapped individuals have undergone greater improvement recently than perhaps any other phases of industrial medicine. Here again management has taken a very stimulating lead. The earlier attitude of using physical examinations simply as a means of eliminating the undesirable and employing only the so-called physically perfect still exists in some plants. Industry still is interested in eliminating the totally unfit and, in this sense, the objective of physical examinations has not changed. The real change is in interpretation of who is fit or unfit to work, and in the varying conditions under which physically handicapped people can be employed profitably.

The first interest which management has in a prospective employee concerns his skill to do the job. The factor of next importance is physical fitness. If both qualifications are above question the problem of placement is simple. It often is the case, however, that the man has the skill but there is some question about his physical ability. It is here that the examining physician always has been called upon for assistance. The assistance originally called for was as to whether, in the doctor's opinion, the man should be given the job.

The present-day trend in physical examinations is to make a more comprehensive examination than was the earlier practice. Various special tests and procedures are employed such as x-rays, electrocardiograms, audiograms, blood serology, etc., in order that a better diagnostic job can be done. The superficial examination, which often involved little more than a brief physical inspection, was not worth very much to anybody. Industry is ready and willing to provide better diagnostic services

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and the employees as a whole are better satisfied with them.

Evaluation of functional capacity is a natural and necessary companion procedure to physical examinations. The foreman is not much concerned about what is wrong with the individual. He wants to know what the man is physically able to do. This information can be given out without revealing the diagnosis, and in a manner which will tell the foreman what he needs to know about the man's ability to lift, climb, stand and engage in the other activities required by the job. Some functional capacity reports contain general information along this line with little or no reference to the degree of exertion possible, or the percentage of the shift time the man can be expected to engage in the various physical activities. The trend seems to be toward giving the employer such information in terms of the approximate percentage of the shift time the man can reasonably be expected to exert himself and the extent to which he may safely exert himself in carrying out the various physical activities. Precise evaluations cannot be made in these respects for obvious reasons but the physician can make more intelligent and accurate estimates than can be arrived at through superficial examinations and broad negative recommendations concerning what the man cannot do.

The success of any physical examination and functional capacity evaluation program depends primarily upon the skill employed in making the examinations, plus the translations of the findings into usable positive suggestions concerning both the general degrees of residual physical capacity and the extent to which the employee can be expected to draw upon these reserves while doing his job. It is essential that the examining physician be thoroughly familiar with the physical activities and hazardous exposures in the plant, otherwise he will be falling down on the total job regardless of how skillful he might be as a diagnostician, or the extent of his knowledge concerning the basic reserves which individuals can utilize in the face of disabilities. To gain this broad knowledge concerning shop conditions, the physician preferably should make personal studies of working circumstances or, at least, have access to precise job analysis data.

Periodic examinations are becoming more popular in industry. They are as essential in keeping up to date on the status of health as inventories of materials and equipment are to the operation and management of the plant. Too much emphasis has been placed upon shop-wide general physical examinations and not enough thought has been devoted to modifications in order to include the diagnostic procedures called for in evaluating effects of exposure to specific hazards. It usually is satisfactory to examine office workers annually but others might need to be examined every six months or even more frequently. It also might be very important to make complete blood counts, quantitative determinations of lead in the urine, or employ other special procedures not normally indicated in the examination of office employees. The trend is toward more extensive use of annual physical examinations in industry but emphasis is being placed upon the graduating of the types and intervals so as to adequately evaluate health progress in relation to the specific hazards of the job.

Industrial Hygiene

Industrial hygiene is a service which when defined in its broadest sense, covers the total preventive medical picture. Another conception of the service relates specifically to the evaluation and control of occupational health hazards. This more restricted definition is followed in this discussion.

Industrial hygiene may utilize the talents of a wide variety of specialists but the basic triumvirate includes the physician, the chemist and the engineer. These three, working together, provide information concerning the physical consequences of exposure, the type and concentrations of the hazardous materials and the corrective steps which should be employed. Working separately, they often can accomplish beneficial results, depending upon the nature of the problem involved. The greatest good usually can be realized, however, through pooling of resources, and this cooperative effort is a typical example of the interdependence of various special interests in the conduct of most phases of preventive medicine.

The plant physician generally has lagged behind in his participation in industrial hygiene. This is particularly true for plants not having their own industrial hygiene chemists or engineers. Industrial hygienists sent out by official agencies often deal with plant engineers or foremen and do not have the opportunity, or take advantage of it, to work with the physician while in the plant. Such instances should be eliminated and the trend is in this direction. The physician is, or should be, the authority in the plant concerning all technical aspects of employee health.

General Environmental Conditions

General plant health conditions related to food handling, toilets, drinking facilities, plant housekeeping, etc., too often are passed up by the plant physician. For this reason, as well as others, some plants still have "slums" which are as abominable as those to be found in the poorest residential areas.

Active interest in such sanitary conditions by the plant physician usually will lead to improvement.

Safety

The role of unsafe acts growing out of physical, physiological and mental maladjustments has been appreciated for a long time. The interest shown by plant physicians in such problems has lagged considerably behind that of the safety engineers. The principal reasons are that many physicians do not appreciate or admit the interdependence of medical and safety programs. Some safety engineers also are short-sighted in this respect and are not inclined to encourage cooperative effort. The earlier conception that safety services should deal primarily with machine guarding and other nonhuman causes of injury was appropriate enough at the time because such unsafe conditions were common and they gave rise to many spectacular and serious injuries. This picture has changed greatly, however, and no longer should be considered the principal interest in the average plant.

Unsafe acts which always have been important causes of accidents are becoming greater in relative importance because the mechanical causes are decreasing rapidly. Increased knowledge concerning accident prone and accident habit characteristics of employees has further high lighted the importance of the human elements responsible for accidents. It is a well known fact that a large majority of accidents are due to these faulty human factors and that such faults predominate among about one-third of the employees. The reasons why one-third or less of the workers cause two-thirds or more of the total accidents vary in type and complexity. The diagnosis and control is simple in many instances but there are others which are not yet amenable to solution.

The interests of safety engineers have definitely shifted toward the more complex realm of accident causes which they commonly refer to as unsafe acts. They are looking to the medical department for more assistance and the response is generally quite favorable. Plant physicians are combining epidemiological inquiry and tactful safety instruction with therapy in a manner which not only improves the therapeutic approach but further individualizes it and utilizes the injury as an object lesson in safety which the employee will remember and pass along for the benefit of uninjured fellow workers. In the course of such dealings, the plant physician gets information which permits him to identify the behavior pattern of the individual. This pattern may be influenced principally by physical defects, physiological incapacity or temperamental disturbance. In any event, the doctor renders an invaluable service to the cause of accident prevention by advising the safety engineer and the foreman as to the corrective steps which should eliminate subsequent trouble.

A Survey of Health Services in Rhode Island

As was stated earlier in this discussion, no attempt was made to mention all of the trends in industrial health service. Neither was it my plan to deal extensively with the examples used. It is felt that the remarks have high lighted some of the more important trends which not only can be evaluated logically but statistically as well. It would seem appropriate at this time to look at the score sheet to see just how far we have traveled toward achievement of some of these goals in industrial health. Numerous national and local surveys of one type or another have been made during recent years. The general findings reveal much encouraging progress but, on the other hand, they reveal many shortcomings.

The status of industrial health coverage in Rhode Island can be illustrated briefly, I believe, by examining the survey findings of an Insurance Company[1]. This survey, made recently, covered nineteen plants located throughout the state. The industries involved probably were slightly substandard in some respects but they were considered to be fairly representative to the extent to which certain plant health facilities and services have been provided by the average plant in the state.

These nineteen plants employed a total of 17,165 workers. The population in each ranged from 125 to 6,500, with the average for the group being about 900 each. By and large, the extent to which the services and facilities were provided was in proportion to the number of employees but there were some exceptions. For example, one of the smallest plants rated along with the best while some of the others with larger populations rated rather poorly.

Seven of the plants employing 12,574 workers employed physicians on a regular schedule basis while the others only called a doctor in when they felt the need to do so. Qualified nursing service was provided full-time by twelve plants employing 14,564 people. Of the other seven plants, which averaged 370 employees each, one had a qualified first aid attendant but the others had no nursing or first aid service measuring up to adequate standards. These same plants also depended upon on-call medical services. Eleven plants employing 13,764 workers provided pre-placement physical examinations but only four of them made studies of physical demands and hazards of jobs. These four plants had 8,945 employees so it appears that the 4,819 workers in the other industries providing pre-placement examinations were examined and placed without the benefits of physical demands

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and hazards data. It is possible, of course, that the examining physicians possessed adequate first hand knowledge of shop conditions by which they were guided in their pre-placement examinations.

Seven of the plants had basic standing orders concerning the handling of cases in the absence of the doctors. Yet, there were five plants employing full-time nurses, in addition to seven not having any nursing care, which did not have standing orders. These latter plants had 6,295 employees, or an average of about 525 each.

In so far as the adequacy of case-handling equipment was concerned, nine plants were rated as adequate or good, eight were below standard and two plants employing 400 and 425 workers, respectively, had no such equipment.

The evaluation of sanitation standards showed that five plants rated good, five were fair and nine were poor. The plants with poor ratings employed 5,060 workers with an average of 562 each. Two of these plants each had over one thousand workers.

The survey report from which the above figures were taken made no specific reference to the quality of services rendered but some obvious conclusions can be drawn. In several plants the services simply did not exist beyond that procured when doctors were called in, or that which was given by inadequately qualified employees. Nothing can be concluded concerning the scope or adequacy of the services rendered by the physicians and nurses employed but it is only fair to presume that they were at least equal to those prevailing throughout the state.

The findings in these nineteen plants have not been used for the purpose of describing industrial medical service in Rhode Island as poorer than those existing in other states. Some states may be somewhat better off but there undoubtedly are others which do not rate so well. The real purpose of discussing the survey findings was to illustrate the general state of development of industrial medical service throughout the country. Although this small sample of plants is statistically inadequate to justify any positive conclusions being derived from the data presented, the impressions are similar to those gained from an analysis of more extensive surveys. The general conclusions are that millions of workers in the country still are being deprived of the type of care which promotes better individual and group health.

Summary

In this discussion, I have given my own impressions concerning the present status of industrial medicine and what some of the trends are. In presenting these impressions and opinions, I have briefly reviewed the history of industrial medicine and attempted to summarize present-day attitudes and accomplishments as influenced by the earlier developments. The earlier developmental problems have left their impressions, some of which are good and others bad. It is obvious that industrial medicine is coming into its own rapidly and on a basis where industrial officials and employees are not only more receptive than in the past, but are becoming more and more insistent that they get good health protection.

The extent, and rate of development, of plant health programs naturally will be governed by economic conditions, specific plant hazards and other factors, but such handicaps will only have retarding influences. The trends concerning quality and quantity of service will not be reversed. The rate of development naturally will be governed quite largely by the attitude and effort of individual physicians and their medical societies. Success along these lines will depend upon the extent to which plant physicians, industrial health committees and the medical profession as a whole condition themselves to deal with the various health and safety problems as being something apart from nonindustrial practice. The next step is to demonstrate the advantages of modern health care through good individual plant programs and group participation in efforts to further enlightening industry and labor as to the benefits they should realize. The indications at the moment are that these goals will be reached and that the medical profession will do its part in bringing adequate health protection to all industrial workers.

Reference

[1] Loss Prevention Department, Liberty Mutual Insurance Company, Boston, Massachusetts.

The RHODE ISLAND MEDICAL JOURNAL

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"BLIND EXPERIMENTS OF TOTALITARIAN RULE"

THE STATEMENTS of junior Senator J. Howard McGrath of Rhode Island before the U. S. Senate Committee on Labor and Public Welfare on the proposed compulsory national health insurance act which the Senator is co-sponsoring, represented in our opinion a series of contradictions in the light of Mr. McGrath's experience in our State.

Let's view one or two of these profound opinions of Senator McGrath.

He attacks the American Medical Association as no longer acting in the interest of the people or the doctors.

The American Medical Association is the medical profession of this country. It is a federacy of the state medical societies, each a sovereign unit just as is each of our state governments in relation to the Federal government. The Rhode Island Medical Society elects a delegate to the House of Delegates of the American Medical Association even as the people of this state elect representatives to Congress. Our Delegate speaks not his personal decision on matters of health and medicine, but rather the stated opinion of the Rhode Island Medical profession even though that opinion runs contrary to his personal likes.

Therefore when Senator McGrath charges the American Medical Association with "undemocratic functioning" he has his tongue well in his cheek. When 268 Congressmen wanted to reduce our taxes recently but 137 plus one Presidential vote said "no", we accepted the inconsistency as part of the democratic process of government. And if Mr. McGrath in his testimony was indicting any officials of the American Medical Association as refusing to carry out the instructions of the doctors of America he should submit proof and give names, and not generalize falsely by indicting the entire medical profession.

Senator McGrath stated relative to Rhode Island that "the State is not afraid of the bugaboo of compulsion" and that "no comprehensive health insurance bill can be truly effective unless, as has been demonstrated by worldwide experience, the employer pays part of the cost." No, we're not afraid of the bogey man, but we are mighty fearful of any plan, federal or state, that will place in the hands of a political bureaucratic entity the complete control of any major phase of the American way of life and living. Anyone who has studied the records knows that European experience in health insurance such as Mr. McGrath would import to our shores has produced no where near the high standard of health care existing in this country.

And if Mr. McGrath is convinced that a sickness benefit plan must have employer financial support to be successful why did he allow the Rhode Island Cash Sickness Compensation plan to be introduced

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and continued under his governorship at the complete expense of the worker who was never given a chance to say whether he preferred the continued tax or an addition in his take home pay?

Senator McGrath states that the compulsory program on a national basis is the only answer. He does not speak from his own experience in Rhode Island when he makes this strong bid for the advancement of socialism in America.

In 1943, Mr. McGrath accepted—six days before the R. I. General Assembly convened for the 1944 session—a proposal worked out by a representative of the Rhode Island Department of Social Welfare for a compulsory hospitalization law that was socialistic in its theory and procedure. Subsequently the proposal was studied by a statewide voluntary health council, picked by Mr. McGrath, that included in its membership representatives of industry, labor, insurance, banking, the clergy, and the medical and legal professions. The proposal was turned down in favor of the advancement of the voluntary method, and at that time, just two and one half years ago, Mr. McGrath stated he believed

> "we are perhaps making as rapid progress under the present (voluntary) system as we could make under compulsory hospitalization, which, without experience, we would have to limit to such groups as are now covered by unemployment insurance and other social programs."

and he further stated at that time that

> "as a result of our study we have found that the pathway to compulsory hospitalization is beset with trials."

Since in the intervening time the Blue Cross, with the support of organizations throughout the state has increased its statewide coverage from 38 per cent to 70 per cent of the population, and the Rhode Island Medical Society is completing its plans for a prepaid voluntary surgical insurance plan to be added to those already operating in 37 other states, it would appear that Mr. McGrath has lost sight of Rhode Island health interests since taking his residence to Washington.

We commend to Senator McGrath his own words, spoken to the Rhode Island General Assembly in 1943, when he said

> "We have been accustomed to see our type of government largely accepted throughout the civilized world. But the two years that have passed since we last met to inaugurate a State government have witnessed terrific political and military upheavals. Today, we, along with our sister States of the Western Hemisphere are fast becoming the last organized societies in which a drama like this can be enacted. Upon our conduct, in the administration of this representative government of free men, depends whether or not an opportunity will exist, even here, to repeat this scene two years from now. It is certain that the world through the power of our example and the practical effectiveness of our type of government to provide people the kind of social, political and economic progress they crave, will either return to the Democratic way of life, or will be driven to further pursue blind experiments of totalitarian rule."

We have had enough blind experiments of totalitarian rule. We believe the people of Rhode Island favor progress by evolution, not by revolution. The willingness to bear the entire cost of cash sickness disability compensation and to top the nation in the purchase of hospitalization service offer ample proof of the desire of Rhode Islanders to solve their health care problems in the American way.

In his zeal for a federal bureaucratic program of additional compulsory taxation, Mr. McGrath, as an exponent of the principles of Thomas Jefferson, should heed that statesman's words that "considering the general tendency to multiply offices and dependencies, and to increase expense to the ultimate term of burden which the citizen can bear, it behooves us to avail ourselves on every occasion which presents itself for taking off the surcharge; that it may never be seen here that, after leaving to labor the smallest portion of its earnings on which it can subsist, the government shall itself consume the residue of what it was constituted to guard."

Our Democratic process guarantees the right of free speech. Mr. McGrath is entitled to express his personal views, but his statements as a public servant warrant consideration of the expressed opinions of the electorate that sent him to Washington to advance the American way of life under which he himself appears to have prospered exceptionally well.

DOCTOR WHEATON HONORED

The medical staff of The Memorial Hospital, Pawtucket, Rhode Island, honored James L. Wheaton, M.D., by presenting his portrait to the board of trustees of the hospital on July 9, 1947 on his 79th birthday. Dr. Wheaton was instrumental in the founding of the hospital in 1910 through his friendship with the late Frank A. Sayles and has been active in the affairs of the hospital since that time.

RICH ASSOCIATES REPLY TO McGRATH TESTIMONY

The testimony presented to the sub-committee on health of the Committee of Labor and Public Welfare of the U. S. Senate by Senator J. Howard McGrath of Rhode Island was submitted to Mr. Raymond T. Rich, chairman of Raymond Rich Associates who are mentioned in Senator McGrath's statement.

The telegraphic answer of the Rich Associates is as follows:

(July 23, 1947)

John E. Farrell,
Rhode Island Medical Society
106 Francis Street
Providence, Rhode Island.

I appreciate your letter. We have requested the Chairman of the sub-committee on Health of the Committee of Labor and Public Welfare of the Senate to read the following statement into the record:

"The statement to your committee by Senator J. Howard McGrath on July 11 accurately quotes the substance of our final report to the American Medical Association. However, in order to avoid a possible confusion of the record, we wish to state that in the course of our work for the American Medical Association we found that with respect to government control of medical economics the Trustees generally reflect the present views of the majority of American doctors."

Raymond T. Rich, Chairman.

PRECEPT AND PERFORMANCE

We have just addressed a very personal question to a caller. We asked him what his income tax was and he said it was $500 a year.

We then asked this caller how many tons of coal he used each year. He said eight.

So if the price of his coal should go up by $1 a ton, his added cost of living would be $8 for the year. President Truman is very eager that the coal operators should not take this $8 from the man and in a statement Monday expressed such hope.

On the same day, President Truman again let it be known that he would veto the tax bill which is to come to him from Congress. The tax bill would reduce our caller's income tax by $100 a year.

It is very bad to charge people higher prices; that is inflation. But it seems there is an exception. The higher price of government is deflation.

Along with his plea to coal operators, Mr. Truman said he hoped that steel men would not raise prices. The price of steel is about 33 per cent above its pre-war figure. Lately the steel men have raised the wages of their own employees by a sizable amount without raising their prices. Now their coal is to cost more but again they are put under pressure not to raise prices.

The cost of government is already several hundred per cent above pre-war. But the very people who are managing government and who in the main are resisting any cuts in the price of government are now advising the steel men and the coal men that they must not increase their prices.

And see how the law of supply and demand is working. People want more steel and things made of steel and they want all the coal that can be mined. But there is no doubt in the world that they want less government.

. . . Editorial, *Wall Street* Journal, July 15, 1947

RHODE ISLAND CASH SICKNESS COMPENSATION

Medical Statistics . . . Benefit Year 1944-1945

Prepared by Hendry C. White, technical assistant to the Rhode Island Unemployment Compensation Board

TABLE 1

Distribution of Benefit Payments By Diagnostic Groups

MALES (All Ages)—Benefit Year 1944-1945

	No. of Cases
I. INFECTIOUS AND PARASITIC DISEASES	
Typhoid fever and dysentery	4
Common communicable diseases of childhood	29
Tuberculosis of the respiratory system	226
Other forms of tuberculosis	13
Syphilis	31
Other infectious and parasitic diseases	105
II. NEOPLASMS	
Malignant neoplasm of the buccal cavity and pharynx	11
Malignant neoplasm of the digestive organs	35
Malignant neoplasm of the respiratory system	8
Malignant neoplasm of the male genital organs	7
Other malignant neoplasm	33
Other nonmalignant neoplasms	192
III. RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION, AND OTHER GENERAL DISEASES	
Rheumatic fever	76
Diabetes mellitus	95
Goiter	26
Other diseases of the endocrine glands	7
Other nutritional and general diseases	15
IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	
Anemia	83
Other diseases of the blood and blood-forming organs	5
V. CHRONIC POISONING AND INTOXICATION	
Chronic poisoning and intoxication	9
VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	
Inflammatory diseases of the central nervous system	14
Intracranial lesions of vascular origin	190
Other diseases of the central nervous system	76
Diseases of the cranial, sympathetic, and peripheral nerves	238
Psychoses	52
Other mental and nervous diseases	299
Diseases of the organs of vision	222
Diseases of the ear and mastoid process	48
VII. DISEASES OF THE CIRCULATORY SYSTEM	
Rheumatic heart disease, inactive	69
Hypertensive cardiovascular disease	178
Other diseases of the heart	1030
Hypertensive vascular disease	269
Other diseases of the arteries	126
Varicose veins and hemorrhoids	384
Other diseases of the circulatory system	172
VIII. DISEASES OF THE RESPIRATORY SYSTEM	
Influenza	390
Acute nasopharyngitis (common cold)	44
Tonsillitis with tonsillectomy	50
Diseases of the pharynx and larynx	164
Bronchitis	504
Pneumonia (all forms)	542
Other diseases of the respiratory system	481
IX. DISEASES OF THE DIGESTIVE SYSTEM	
Diseases of the buccal cavity and esophagus	34
Ulcer of the stomach and intestines	520
Diarrhea and enteritis	145
Appendicitis	344
Hernia	1014
Functional digestive disturbances	16
Other diseases of the stomach and intestines	198
Diseases of the liver and gall-bladder	225
Other diseases of the digestive system	14
X. DISEASES OF THE GENITO-URINARY SYSTEM	
Nephritis	61
Other diseases of the kidneys and ureters	124
Other diseases of the urinary system	48
Diseases of the prostate	119
Other diseases of the male genital organs	84
XII. DISEASES OF THE SKIN	
Diseases of the skin	574
XIII. DISEASES OF THE BONES AND ORGANS OF MOVEMENT	
Arthritis	524
Other diseases of the bones and joints	417
Other diseases of the organs of movement	101
XIV. CONGENITAL MALFORMATIONS	
Congenital Malformations	11
XVI. OTHER AND ILL-DEFINED DISEASES	
Ill-defined diseases	695
All other diseases	61
XVII. INJURIES AND POISONINGS	
Acute poisoning	14
Injury by foreign body and general effects of external causes, including concussion	108
Compound fracture	134
Simple fracture	1372
Dislocation, sprain, or other joint injury without fracture	1068
Burn or scald	172
Cut, laceration, or puncture wound	385
Abrasion, contusion, or other superficial injury	343
Other or unspecified injury	1553
TOTAL	17,029

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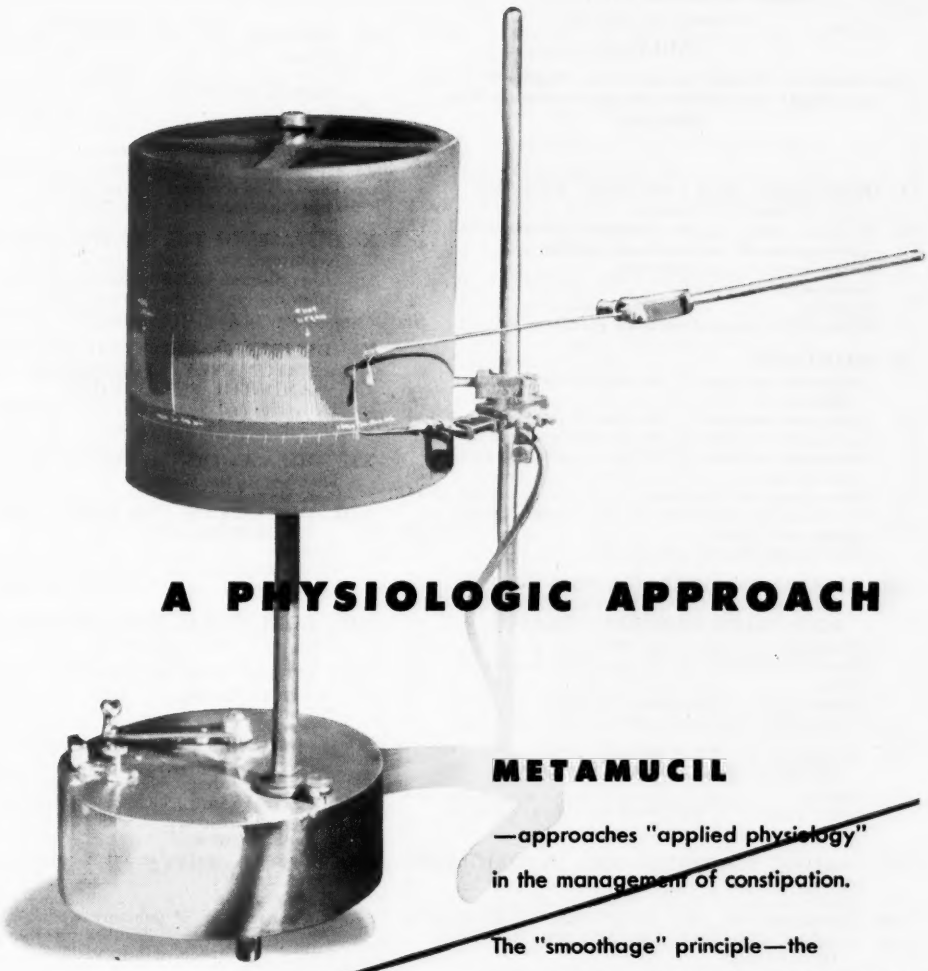

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

CASH SICKNESS STATISTICS

continued from page 596

TABLE 2

Distribution of Benefit Payments By Diagnostic Groups MARRIED FEMALES (All ages)—Benefit Year 1944-1945

	No. of Cases
I. INFECTIOUS AND PARASITIC DISEASES	
Typhoid fever and dysentery	3
Common communicable diseases of childhood	12
Tuberculosis of the respiratory system	46
Other forms of tuberculosis	3
Gonococcus infection	1
Syphilis	4
Other infectious and parasitic diseases	50
II. NEOPLASMS	
Malignant neoplasm of the buccal cavity and pharynx	2
Malignant neoplasm of the digestive organs	4
Malignant neoplasm of the respiratory system	1
Malignant neoplasm of the female genital organs and breast	20
Other malignant neoplasm	14
Nonmalignant neoplasm of the female genital organs and breast	238
Other nonmalignant neoplasms	83
III. RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION, AND OTHER GENERAL DISEASES	
Rheumatic fever	51
Diabetes mellitus	108
Goiter	88
Other diseases of the endocrine glands	37
Other nutritional and general diseases	14
IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	
Anemia	267
Other diseases of the blood and blood-forming organs	2
V. CHRONIC POISONING AND INTOXICATION	
Chronic poisoning and intoxication	1
VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	
Inflammatory diseases of the central nervous system	4
Intracranial lesions of vascular origin	26
Other diseases of the central nervous system	12
Diseases of the cranial, sympathetic, and peripheral nerves	169
Psychoses	19
Other mental and nervous diseases	608
Diseases of the organs of vision	75
Diseases of the ear and mastoid process	45
VII. DISEASES OF THE CIRCULATORY SYSTEM	
Rheumatic heart disease, inactive	36
Hypertensive cardiovascular disease	134
Other diseases of the heart	400
Hypertensive vascular disease	380
Other diseases of the arteries	19
Varicose veins and hemorrhoids	263
Other diseases of the circulatory system	229
VIII. DISEASES OF THE RESPIRATORY SYSTEM	
Influenza	250
Acute nasopharyngitis (common cold)	48
Tonsillitis with tonsillectomy	47
Diseases of the pharynx and larynx	124
Bronchitis	296
Pneumonia (all forms)	132
Other diseases of the respiratory system	275
IX. DISEASES OF THE DIGESTIVE SYSTEM	
Diseases of the buccal cavity and esophagus	45
Ulcer of the stomach and intestines	94
Diarrhea and enteritis	102
Appendicitis	268
Hernia	69
Functional digestive disturbances	18
Other diseases of the stomach and intestines	94
Diseases of the liver and gallbladder	265
Other diseases of the digestive system	19
X. DISEASES OF THE GENITO-URINARY SYSTEM	
Nephritis	50
Other diseases of the kidneys and ureters	94
Other diseases of the urinary system	61
Diseases of the female genital organs and breast	1210
XI. DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	
Deliveries and complications of pregnancy, childbirth, and the puerperium	4907
XII. DISEASES OF THE SKIN	
Diseases of the skin	302
XIII. DISEASES OF THE BONES AND ORGANS OF MOVEMENT	
Arthritis	508
Other diseases of the bones and joints	173
Other diseases of the organs of movement	48
XIV. CONGENITAL MALFORMATIONS	
Congenital malformations	5
XVI. OTHER AND ILL-DEFINED DISEASES	
Ill-defined diseases	930
All other diseases	67
XVII. INJURIES AND POISONINGS	
Acute poisoning	4
Injury by foreign body and general effects of external causes, including concussion	30
Compound fracture	18
Simple fracture	287
Dislocation, sprain, or other joint injury without fracture	365
Burn or scald	39
Cut, laceration, or puncture wound	94
Abrasion, contusion, or other superficial injury	99
Other or unspecified injury	438
TOTAL	15,343

TABLE 3

Distribution of Benefit Payments By Diagnostic Groups OTHER FEMALES (All ages)—Benefit Year 1944-1945

	No. of Cases
I. INFECTIOUS AND PARASITIC DISEASES	
Typhoid fever and dysentery	2
Common communicable of childhood	25
Tuberculosis of the respiratory system	51
Other forms of tuberculosis	3
Malaria	2
Syphilis	2
Other infectious and parasitic diseases	31
II. NEOPLASMS	
Malignant neoplasm of the buccal cavity and pharynx	2
Malignant neoplasm of the digestive organs	5
Malignant neoplasm of the respiratory system	2
Malignant neoplasm of the female genital organs and breast	12
Other malignant neoplasm	4
Nonmalignant neoplasm of the female genital organs and breast	80
Other nonmalignant neoplasms	62

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CASH SICKNESS STATISTICS

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	No. of Cases
III. RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION, AND OTHER GENERAL DISEASES	
Rheumatic fever	56
Diabetes mellitus	28
Goiter	51
Other diseases of the endocrine glands	19
Other nutritional and general diseases	7
IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	
Anemia	138
Other diseases of the blood and blood-forming organs	1
V. CHRONIC POISONING AND INTOXICATION	
Chronic poisoning and intoxication	2
VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	
Inflammatory diseases of the central nervous system	3
Intracranial lesions of vascular origin	10
Other diseases of the central nervous system	16
Diseases of the cranial, sympathetic, and peripheral nerves	59
Psychoses	19
Other mental and nervous diseases	307
Diseases of the organs of vision	64
Diseases of the ear and mastoid process	30
VII. DISEASES OF THE CIRCULATORY SYSTEM	
Rheumatic heart disease, inactive	27
Hypertensive cardiovascular disease	51
Other diseases of the heart	147
Hypertensive vascular disease	98
Other diseases of the arteries	13
Varicose veins and hemorrhoids	74
Other diseases of the circulatory system	84
VIII. DISEASES OF THE RESPIRATORY SYSTEM	
Influenza	168
Acute nasopharyngitis (common cold)	30
Tonsillitis with tonsillectomy	70
Diseases of the pharynx and larynx	116
Bronchitis	166
Pneumonia (all forms)	86
Other diseases of the respiratory system	168
IX. DISEASES OF THE DIGESTIVE SYSTEM	
Diseases of the buccal cavity and esophagus	20
Ulcer of the stomach and intestines	34
Diarrhea and enteritis	67
Appendicitis	456
Hernia	26
Functional digestive disturbances	3
Other diseases of the stomach and intestines	53
Diseases of the liver and gallbladder	68
Other diseases of the digestive system	12
X. DISEASES OF THE GENITO-URINARY SYSTEM	
Nephritis	24
Other diseases of the kidneys and ureters	34
Other diseases of the urinary system	21
Diseases of the female genital organs and breast	258
XI. DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	
Delivery with live or stillbirth	131
XII. DISEASES OF THE SKIN	
Diseases of the skin	171
XIII. DISEASES OF THE BONES AND ORGANS OF MOVEMENT	
Arthritis	156
Other diseases of the bones and joints	74
Other diseases of the organs of movement	38
XIV. CONGENITAL MALFORMATIONS	
Congenital malformations	8
XVI. OTHER AND ILL-DEFINED DISEASES	
Ill-defined diseases	436
All other diseases	20
XVII. INJURIES AND POISONINGS	
Acute poisoning	3
Injury by foreign body and general effects of external causes, including concussion	28
Compound fracture	16
Simple fracture	232
Dislocation, sprain, or other joint injury without fracture	169
Burn or scald	27
Cut, laceration, or puncture wound	62
Abrasion, contusion, or other superficial injury	58
Other or unspecified injury	205
TOTAL	5,301

PSYCHIATRIC LESSONS LEARNED IN THE ARMY

concluded from page 586

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THE THIRD NEW ENGLAND INSTITUTE FOR HOSPITAL ADMINISTRATORS

THE Third New England Institute for Hospital Administrators was held at Brown University, June 19 through 28th. There were 68 registrants from 12 states, including a representative of the Naval Hospital in Newport and Veterans' Administration hospitals.

These Institutes have been carried on at the University of Chicago for 14 years and the previous two in New England were held just prior to the war at Harvard Medical School. The student body indicated that the third New England Institute was one of the outstanding ones in their experience, due to the excellent faculty both from Brown University and the hospital field.

The Institute was designed for administrators and assistant administrators of hospitals, and as the majority are from hospitals of under 100 beds without schools of nursing and without interne training programs the scope of the Institute was naturally designed to meet the particular needs.

The general plan for the Institute included field trips, demonstrations and seminar sessions. The resources of Brown University and its community made possible an innovation in the nature of brief luncheon presentations on liberal art subjects.

The curriculum content was divided into six major divisions. "Human Relations" was one of the lead subjects with participation by experts Prof. Philip Taft of Brown University, Prof. Paul Pigors of Massachusetts Institute of Technology, and Mrs. Ann Saunders, Personnel Specialist of the American Hospital Association. Professor Taft provided a foundation for thinking on this subject by discussing labor and the present day world, and the impact on the hospital of the changes in labor relations. This was followed by Professor Pigors who outlined the importance of supervisors to a successful organization and stressed the importance of their training and their need for a comprehensive understanding of the thinking of top management. Mrs. Saunders tied this material in to the administrator of a hospital and his responsibility in this respect as a prerequisite to a successful and well-ordered hospital.

The medical staff of a hospital, the backbone of modern hospital service, came in for some major attention with Dr. Francis J. Bean and Dr. Alex M. Burgess discussing organization. Dr. Charles Wilkinson of the University of Michigan interpreted the medical staff development and interne and resident training in relation to a hospital system which is primarily work eminating from the University of Michigan Medical School and Hospitals. Dr. Frederick T. Hill carried two important medical staff subjects—first, "Group Medical Practice", and "Medical Staff Audit", pointing out not only the mechanics involved and the value in present day care of the patient but the need for comprehensive understanding and control of medical practice within the hospital.

Organization and management was discussed by leaders from the faculty of Brown University, Harvard School of Business and from the hospital field, all stressing the need for fundamental organization to modern and satisfactory hospital practice.

The importance of close co-ordination between public health development and hospital development and the need for a broad concept of hospital service on the part of the administrator was brought out by such able leaders as Dr. Ira V. Hiscock, Professor of Public Health at Yale University, Dr. Charles F. Wilinsky, Director of Beth Israel Hospital, and Reverend Donald A. McGowan, Director of Catholic Hospitals, Boston.

The hospital of tomorrow envisioned as a much greater public service enterprise than was the original concept when many of our voluntary hospitals were founded was very adequately handled by Dr. Charles A. McDonald of Brown University, Dr. Nathaniel W. Faxon of the Massachusetts General Hospital, Mr. James A. Hamilton and Dr. Frank R. Bradley both professors of Hospital Administration at Minnesota and Washington Univerties respectively.

Each lecture contributed greatly to the thinking and particular aspect of hospital management and yet the entire emphasis for the entire Institute and of each lecturer was focused on the fundamental reason for hospitals—the care of the individual patient.

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WOMAN'S AUXILIARY

Mrs. Herbert E. Harris, President of the Woman's Auxiliary announces the following committee appointments:

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Mrs. James C. Callahan
Mrs. Louis C. Cerrito
Mrs. H. Lorenzo Emidy
Mrs. Joseph C. Kent
Mrs. Earl Mara
Mrs. H. Frederick Stephens

Editorial Committee

Mrs. J. Lincoln Turner, *Chairman*
Mrs. Charles L. Farrell
Mrs. Francis L. Burns

Program Committee

Mrs. Charles F. Gormly, *Chairman*
Mrs. Thomas S. Flynn
Mrs. Martin O. Grimes
Mrs. Joseph K. Harrop
Mrs. Joseph C. Johnston
Mrs. William J. Johnson
Mrs. H. Frederick Stephens
Mrs. Harry Triedman

Revision Committee

Mrs. Henry S. Joyce, *Chairman*
Mrs. Stanley D. Davies
Mrs. Charles L. Farrell
Mrs. Arcadie Giura
Mrs. William N. Hughes

Legislative Committee

Mrs. Herman A. Lawson, *Chairman*
(Remainder of Committee to be announced later)

Public Relations Committee

Mrs. James P. O'Brien, *Chairman*
(Remainder of the Committee to be announced later)

Historian

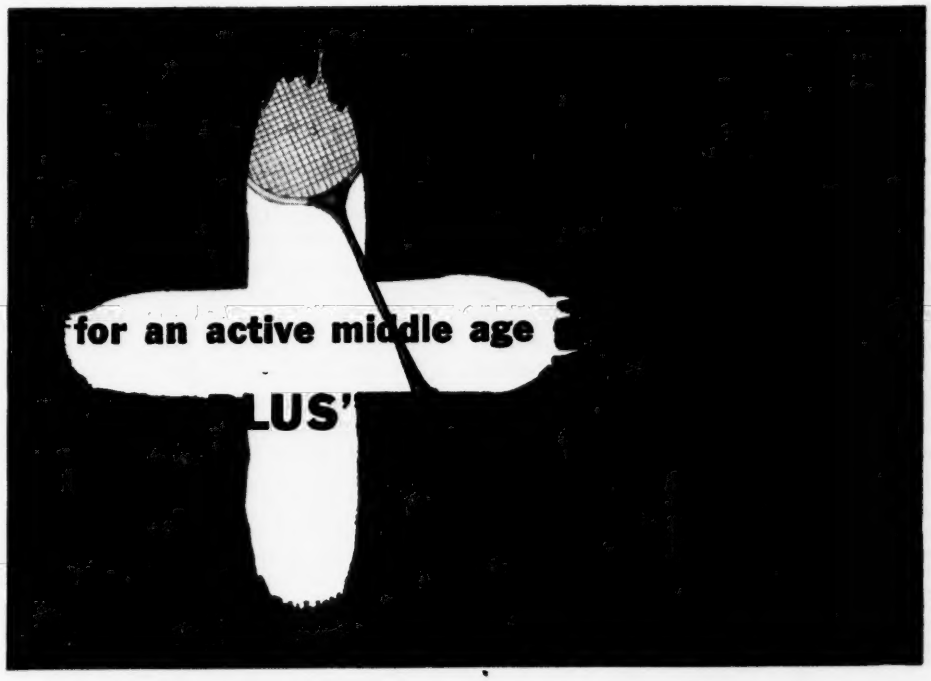
Mrs. Joseph C. Johnston

OCTOBER MEETING PLANNED

Present plans call for a meeting of the Auxiliary to be held at the Rhode Island Medical Library in October. The date has been tentatively set as Monday, October 27, and an all day meeting is contemplated. The morning session would be concerned with organizational work of the Auxiliary, and the afternoon meeting would be open to the general public for a discussion of some pertinent public health problem. Complete details will be announced early in the Fall.

MEMBERSHIP ROSTER

The Auxiliary membership roster now numbers approximately 200. The wife of any physician who is a Fellow of the Rhode Island Medical Society is eligible for membership, and applications together with annual membership dues in the amount of $3.00 should be made to Mrs. Charles L. Farrell, secretary, or Mrs. Jesse P. Eddy, 3rd, treasurer.



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PURPOSES OF A STATE MEDICAL JOURNAL*

JOHN E. FARRELL

(Executive Secretary, Rhode Island Medical Society, and
Managing Editor, Rhode Island Medical Journal)

A STATE MEDICAL JOURNAL, as the official printed organ of a state medical society, may be considered to have as its primary purpose the presentation of the news and views of the medical profession in that state, both to the physicians and to the public generally. Thus, the state medical journal may be recognized as the newspaper of the local medical profession.

With that thought in mind I have amended my favorite definition of a newspaper to fit the medical journal, and I offer this definition:

A state medical journal is a business of creating and focusing professional and public attention by means of the periodical publication by printing, of information concerning recent, current or prospective events concerning medicine and public health; of interpretation of and comment upon such events; of entertaining and instructive matter not necessarily dealing with current happenings; and of selling as advertising space the attention and interest thus attracted and focussed.

That the publication of a state medical journal is a business demanding the time, energy and ability of its guiding staff any editor or managing editor will attest. That many of our state medical journals, including the one with which I have a direct responsibility, fall far short of what constitutes real journalism is readily admitted. Therefore, in the observations that follow the intention is to observe what would, in my opinion, constitute some of the qualities of an excellent state medical journal, thereby fulfilling adequately any stated or understood purposes of that type of a publication.

The state medical journal is not intended, nor utilized, to present original scientific clinical discoveries. Undoubtedly there was a day when the journals were so used, but with the creation of national and specialty journals, and with the printing of research studies by foundations and other organizations, the role of the state journal has been that of reflection of local thinking and findings. Through the medium of the annual state scientific assembly some clinical papers are available from national or regional authorities, but for the most part the state journal must rely upon home talent for articles. And that is as it should be, for the purpose of the book is to bring the local profession up to date on local work.

The state journal should seek to present short, current medical papers, tinged by the personality of the author. To be of real interest such articles must be timely, to the point, and headed by as brief and informative title as possible. Unfortunately most of our journals for one reason or other violate all these conditions. We depend upon a backlog of papers accruing from our annual meeting, and often we disregard the timing of our releases according to the season of the year in which they are published. We often fail in editing, allowing the author to take a running start that frequently outlasts the patience of the reader. Or again, we allow the contributor to inflict upon us a double column heading of great length that either confuses the would-be reader, or sends him hastily to other pages of the book.

One important source of clinical material for state medical journals that has a good reader interest is that of clinicopathological conferences at leading hospitals. The New England Journal of Medicine has set a pattern in this respect, and many of the state journals have emulated it to advantage. We have adopted this idea in Rhode Island and our Journal has accepted the expense of verbatim stenotype reporting of some of the bi-monthly conferences at Rhode Island Hospital. They have proved most informative.

As a chronicler the state medical journal should open its pages to the reporting of state and community programs, both public and private, that involve medical care or public health. There are many organizations allied to the medical profession that attract fine speakers to their meetings whose addresses, while directed for the most part to a lay audience, are worthwhile reading for the physician if he is to have a broad viewpoint of the public interest and participation in the work to which he has devoted his life. And in the acceptance of some manuscripts the Journal must assume the role of the newspaper by reporting both sides of a controversy, and not always maintain a biased or one-sided view. I am mindful in this connection of the action of our Journal a year ago in reporting in full, with the lead pages facing, the addresses of your Dr. Joseph Howard and of Mr.

* Presented at the Semi-Annual Conference of County Medical Association Presidents and Secretaries of the Connecticut State Medical Society, New Haven, March 20, 1947

Arthur J. Altmeyer, Chairman of the Federal Social Security Board, on the question of voluntary versus government health care.

The Editorial Function

The citing of this example of reporting a controversy brings me to what I consider the most important, and the most neglected, purpose of a state medical journal. The editorial is the heart of the journal, but it does not beat very loudly in most states, and it takes its place as the number one malady of our publications.

Our scientific and clinical presentations are necessarily directed to the physicians in our immediate areas. Our editorials must assume a broader role—that of interpreting what has happened in the realm of medicine and public health, both locally and nationally, of explaining the relations of one thing to another, and their functions. Our editorials must reflect the opinions and the decisions of the medical profession in our states, and they must speak not alone to the membership of our societies, but to the general public. We must follow the precept of Joseph Pulitzer and talk to a nation, not to a select committee.

A good editorial department will make a journal live. It will exert force upon the opinions of the people in matters of vital importance regarding their health. The editorial must not reflect the viewpoint of the editor; it must represent objectively the thinking of the Society as seen through the eyes of a well-informed editorial staff. We should allot no space for narrow-minded opinions, nor should we be prejudiced unduly against all who disagree with our opinions.

But when we know that we are being attacked, or when we see anywhere the threat to the profession or to the medical care of the people, we cannot be militant enough. Too often do the state journals become verbose in editorials without pointing definitely and with finality to what is wrong, why it is wrong, and why the medical profession challenges the evil as it sees it. In my opinion our Journals too often hesitate to enter public controversies because the attending publicity is considered unfavorable, even though the cause is just.

We are not alone facing this problem. As Sevellon Brown, Editor and Publisher of the Providence Journal-Bulletin, pointed out recently at the seminar for editorial writers of the American Press Institute, ". . . candor compels the confession that today, far, far too many publishers are not giving their editorial staffs the support they need for the task of producing a reflective page of opinion upon so complex and bewildering a social and political scene . . . our editorial staffs are undermanned and opportunity for study, contact and reflection for editorial writers is far too meager. A quantity of production utterly irreconcilable with quality is required as a daily routine. The result—words, words, word."

State medical journals may well heed this thinking. When valuable space is given month after month to so-called editorials that consist of reprints from AMA or press news releases, programs of annual or other meetings with no comment thereon, etc., then truly the editorial function is submerged by the news function. Undoubtedly in many states the editorial work is left to one or two men. Certainly it would appear that little conference study has gone into some of the editorial pages I have read in recent months. A well chosen staff picked for ability to interpret medical and health problems, particularly on the local level, and meeting monthly in conference to shape the editorial policies is, in my opinion, the major solution to the problem.

News Departments

The various news departments of the state medical journals vary according to local tastes, but for the most part they are fairly well organized, thus bespeaking the desire to satisfy the orderly thinking of the physician-reader. There are a few ob-

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PURPOSES OF A STATE MEDICAL JOURNAL

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servations, however, that I would make. Some journals give good coverage to meetings of the state society, but are not as solicitous of the district society meetings. Perhaps this situation is due in measure to the fact that the district societies are not organized to report as promptly of their meetings. But this is all the more reason why the state journal editorial staff should be alert to reach the county secretary by telephone, or mail, the day after his meeting to seek timely reports advantageous both to the success of the journal and to the satisfaction of the membership involved.

Many large states seek county society news through press clipping services. That is undoubtedly the ideal way to get accurate, prompt and complete coverage, for those not utilizing such service the task is an endless one of reaching the county secretary. The answer would appear to be to seek an editorial correspondent in each county upon whom the journal may rely for prompt filing of local news, as well as the reporting of major local problems worthy of editorial study and interpretation.

One criticism that I have of many state journals is their indiscriminate use of what we call "fillers." These are items sent as press releases by scores of national, sectional, and local agencies. Some journals make no effort to edit such copy, printing it verbatim, utilizing valuable space to tell in many words a message that has appeal to a very limited number of the membership. Several journals have done outstanding jobs in correlating all such news into a section. In Rhode Island we run, as occasion demands, a section titled "Through the Microscope" whereby we attempt to edit the highlights of scores of releases and news items culled from other bulletins and journals. We make brief statements that make for easy, and we hope, interesting reading.

Of paramount importance in the departments is the necessity for the reporting of local news. Most of our membership subscribes to one or more national medical publications and therefore has information on national issues. What they want in our state journal is state news stories, and what the state medical society contemplates on the local level to meet both local and national problems.

The Role of Advertising

Advertising in state medical journals has been treated, until recent years, as a liability rather than as an asset. Many journals have accepted advertisements to secure financial returns to support the publication, and then loaded the displays in the back of their books. Advertisers, faced with the necessity of reaching the physician through the

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PURPOSES OF A STATE MEDICAL JOURNAL

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professional journals accepted the space offered and optimistically hoped that the journal would prove sufficiently interesting to its readers to attract them to the display ad section.

In recent years the situation has changed decidedly. For one thing the journals have recognized that most of the advertising displays were decidedly informative, colorful, and in many instances more interesting and timely than some of the news copy submitted to the readers. The trend spread to bring the displays out of the seclusion of the rear of the book, and to grant them a fair opportunity to capture the attention of the physician.

The advertisers for their part have begun to realize that the state medical journal is their best salesman. They have begun to realize that state journals are read widely in local areas, for the axiom that the value of news depends largely on the familiarity of the reader with the locality in which the event happens, and with the persons, places, things and circumstances involved in it, holds equally true for the state medical journal as it does for the daily newspaper. Our state medical journals include articles by local physicians, news of local physicians and local events and interpretations of local problems as well as national issues affecting the local medical profession. Thus our state journals when well edited have a far greater reader interest than the national or sectional journal can ever have, in our individual states.

Advertising in the state medical journal is directed to the profession, not the general public. The bulk of it comes from reputable advertising agencies representing outstanding pharmaceutical companies, and copy is carefully written and edited to prevent the publication of unwarranted claims. With the tightening of the national Food and Drug Law there is little opportunity for false advertising in any publication, but the mere fact that a product is advertised in a state medical journal in no manner implies a recommendation of it. It is to be doubted that any physician draws such a conclusion. Even the Council on Pharmacy of the American Medical Association states that in admitting an article in the New and Non-official Remedies it does not imply any endorsement whatever of the product. There is an honest difference of opinion on many therapeutic questions, and it is natural that a manufacturer should be partial to his own product. The physician knows that and uses his own good sense accordingly.

There is need for wider exploration of ways to improve advertiser relationships with the journals. The present strong position should be cemented with advertising services by the journal for both the buyer and the consumer. In Rhode Island we have taken several such steps. Our latest has been the publication of a directory of the sales representatives of our advertisers detailing physicians in Rhode Island and Southeastern Massachusetts. This printed directory has been supplied to every physician in those areas for personal reference. It offers a fine service to the busy doctor, and an even greater one to the detail man servicing his needs.

The Pattern for the Future

The state medical journals are presently enjoying an enviable position. They have won substantial advertising support which has enabled them to improve their publications as regards format and news coverage. They have proved to many advertisers that the reader interest of the state journal is the greatest in the professional publication field.

With the engaging of full-time executive officers by many state societies the administrative and mechanical phases of the journals are in excellent hands. The future success, then, depends upon the work of the editorial staff.

Professional advice should be sought to improve the publications, and conferences such as the writer has advocated for the past four years should be held on a national or regional basis to permit a reflective study of the journals aimed towards their improvement. Editorial boards should meet regularly, should explore ways to improve their book, and most important, should make the editorial department a live, active voice in the shaping of local problems of whatever nature that affects health or medicine.

"THE PURPOSE OF A MEDICAL JOURNAL"

Under this title John E. Farrell, Executive Secretary of the Rhode Island Medical Society, addressed the county society secretaries of Connecticut, recently. Mr. Farrell, one of the "live" secretaries, is well qualified to speak on this subject anl much that he had to say is worthy of note.

He compares medical journalism with lay journalism —they both have, or should have—the same objectives, that of furnishing to their readers reports of current and prospective events in their respective fields. He further observes that too many of our journals do not come up to the mark of *real* journalism and offers some suggestion for improvement.

He prefers, and in this we agree, that State Journals will do well to leave original scientific clinical discoveries with the national and specialty publications. "The State Journal should seek to present the short, current medical papers, tinged with the personality of the author." Again shall we have to agree with Mr. Farrell.

Again, he speaks of the "seasonableness" of the papers, a most important thing. Certain diseases seem to select certain seasons of the year for their activities and it is at this time that articles, written from personal experiences, will be best received by readers. He also favors our keeping in touch with many of the "health organizations," even though lay controlled; their annual meetings often provide interesting reading material for physicians.

Mr. Farrell criticizes the editorial department of many of our journals, most of them, in fact; says that while the editorial department is the heart of these journals, "it does not beat loudly in most states." Narrow-minded opinions and controversial matters should be avoided—we are speaking not only to our own membership but to the medical profession of America.

He believes we should be more militant, especially when attacked as we have been for several years past, too many words are used in talking about these things, too few in pointing out why this or that is wrong.

He then strikes a new note when he speaks of the reporting of medical meetings within one's state—too much attention is given to reports of the annual state meeting, too little of what goes on in the county societies. He strongly criticizes the all-too-frequent use of "fillers," these items being sent in by various agencies and too often not edited, but used "as is."

His address is of unusual interest to those concerned with the publication of our state journals and covers the field very nicely. However, we should like to make this comment—we do not believe that a single pattern can be set for all state medical journals to follow; there is too much variation throughout the states. What will be found of the greatest interest in one state will fall absolutely flat in another. Some states, for example—Indiana being a devout believer in the plan—have a regular news notes and personals department. Our readers like this, so they tell us—on the other hand it would fail to interest perhaps some other communities. We like to feel that our publication is, primarily, for Hoosier physicians; we have lived a long time among them and believe we know them.

* * *

. . . Editorial, *THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION*, July, 1947

PRELIMINARY REPORT OF HEALTH DEPARTMENT STATISTICS

PROVIDENCE * RHODE ISLAND

1946

VITAL STATISTICS	1946	1945	1944
Deaths all	3173	3158	3268
Deaths under 1	269	227	275
Deaths over 70	1157	1120	1241
Births	10215	8232	8192
Marriages	3903	2814	2619
Infant Mortality	26.33	27.57	33.57
Death Rate	11.92	11.91	12.42
Birth Rate	38.40	31.06	31.14

PRINCIPAL CAUSES			
1. Heart Disease	1054	1082	1057
2. Cancer	484	446	451
3. Pneumonia	108	115	174
4. Nephritis	182	188	198
5. Cerebral Hemorrhage	216	224	247
6. Auto Accidents	49	41	28

LABORATORY EXAMINATIONS			
Chas. V. Chapin Hospital	33137	27888	27113

MILK DEPARTMENT			
No. Samples Tested	16873	22373	23621
No. Licenses Issued	1389	1329	1411

PHYSICIANS			
No. Visits to Sick Poor	986	1788	2266

DIPHTHERIA IMMUNIZATION	1946	1945	1944
No. Schick Tests	7217	7084	7900
No. Alum Toxoid Treat.	4394	4715	4199

SMALLPOX IMMUNIZATION			
No. Vaccinated	2208	2512	2871

INSPECTORS			
Food Inspector:			
Inspections	9041	8687	8133
Licenses Renewed	1917	1779	1650
New Licenses	210	92	100
Transfers	150	131	103
Licenses Withdrawn	0	1	0
Licenses Not Approved	5	0	2
Licenses Revoked	1	1	3
Sanitary Division:			
No. of Visits	6225	7524	6855
Animal Bite Visits	1461	1248	1270
Kennel Lic. Approved	36	78	80
Garbage Lic. Approved	12	21	20

NURSING VISITS			
Communicable Diseases	6288	4626	7114
Parochial Schools	4662	3200	5010
Tuberculosis — Home	7466	4958	4845

COMMUNICABLE DISEASES	CASES 1946 Res	CASES 1946 Non Res	CASES 1945 Res	CASES 1945 Non Res	*DEATHS* 1946 Res	*DEATHS* 1946 Non Res	*DEATHS* 1945 Res	*DEATHS* 1945 Non Res
Diphtheria	11	10	5	3	0	1	1	0
Scarlet Fever	186	56	256	60	0	0	0	0
Measles	1079	14	106	0	0	0	0	0
Whooping Cough	1097	26	994	25	2	1	2	2
Pulmonary Tuberculosis	180		390		51	8	55	14
Septic Sore Throat	1	0	5	0	0	0	0	0
Streptococcus Sore Throat	36	3	26	1	1	1	0	1
Gastro Enteritis	26	14	65	25	5	2	5	6
Bacillary Dysentery	7	0	30	9	0	0	0	0
Poliomyelitis	9	79	0	4	0	5	0	0
Epidemic Meningitis	12	17	17	17	3	4	2	1
Typhoid Fever	0	1	3	2	0	0	0	0
Paratyphoid Fever	3	3	6	1	0	0	0	0
Epidemic Encephalitis	0	0	1	4	0	0	0	1
Ophthalmia Neonatorum	0	0	1	1	0	0	0	0
Undulant Fever	1	2	1	0	0	0	0	0
Infectious Mononucleosis	4	1	4	3	0	0	0	0
Trichinosis	12	7	2	0	0	0	0	0
Tetanus	1	1	0	1	0	0	0	0

* Includes Non-Residents*

MICHAEL J. NESTOR, M. D.
Superintendent of Health

Crystals of pure Streptomycin Calcium Chloride Complex

Announcing

A New, Highly Improved Form of STREPTOMYCIN

The development of Streptomycin Calcium Chloride Complex Merck constitutes an important advance in Streptomycin therapy. This improved form of Streptomycin provides these noteworthy advantages:

- INCREASED PURITY
- MINIMUM PAIN ON INJECTION
- UNIFORM POTENCY
- DECREASED TOXICITY

STREPTOMYCIN
CALCIUM CHLORIDE COMPLEX
MERCK

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

In Canada: MERCK & CO., Ltd. Montreal, Que.

LITERATURE AVAILABLE ON REQUEST

MERCK
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SENATORIAL VIEWS ON HEALTH INSURANCE

SENATOR TAFT: We recognize that the Government has an obligation to give free service only to those people who are unable to pay for it themselves in full, directly or through voluntary health insurance. State medicine proposes that the Government tax everybody to the tune of about four or five billion dollars a year, and then give medical aid free to over one hundred million people. That is what socialism is. If free medical care for all at the expense of taxation, why not free food, clothing, housing for all at the expense of taxation?

SENATOR McGRATH: I believe that Senator Taft misconstrues the issue entirely. We are talking about health for the American people, not health for only those who are unable to pay for it.

SENATOR TAFT: Those who are able to pay for it can pay for it. My only insistence is that they do pay for it, not that the Government pay for it.

SENATOR McGRATH: The fact of the matter is that they are dying by the hundreds———

SENATOR TAFT: (Interposing): Nonsense, Senator McGrath!

SENATOR McGRATH: More deaths are occurring in the wealthy classes—that is, when I say the wealthy classes, I refer to the middle classes—than in the poorer classes.

SENATOR TAFT: And our death rate is steadily declining, owing to the excellent service given by a free medical profession in the United States.

SENATOR McGRATH: Our plan proposes that the doctors be paid for that service so that they don't have to give it free.

* * *

SENATOR TAFT: Compulsory insurance is not insurance at all; it is taxation. Insurance is the payment of something in return for taking care of a certain risk.

SENATOR McGRATH: For an anticipated risk.

SENATOR TAFT: This tax has no relation to that risk at all. A man with a $3600 income is going to have to pay $144, even though he has only himself and his wife. A fellow with a $1000 income pays $40 a year though he has a wife and six children. It is a principle of taxation.

SENATOR McGRATH: Senator, you are still using percentage figures that are beyond anything in the bill.

SENATOR TAFT: No, no, this will be a 4 per cent tax.

SENATOR McGRATH: But he is not paying the 4 per cent.

SENATOR TAFT: If that were so, why didn't you introduce a tax bill. It is easy to introduce a bill about spending money like this, but you have not introduced a tax bill providing the money.

SENATOR McGRATH: Your bill is a spending bill. Your bill proposed to appropriate $200,000,000, and we do not appropriate one cent from the treasury.

SENATOR TAFT: Your bill will cost $5,000,000,000, and you don't dare tell where you are going to get it. You don't dare introduce a tax bill that will take care of it.

SENATOR McGRATH: We are going to get it from the people of America who are begging for this kind of program, and dying for lack of it.

SENATOR TAFT: You are going to get it through a pay roll tax, I presume, but you don't introduce the pay roll tax bill; you don't bring that in and tell us about it. Presumably it is going to be a pay roll tax bill so that a man with $2500 income is going to have to pay $100 a year for medical service. He can go and get voluntary medical insurance for about $87 for a family of five in Michigan today.

* * *

. . . Abstracted from the *American Forum of the Air* radio discussion on "WHAT SHOULD CONGRESS DO ABOUT HEALTH INSURANCE", June 3, 1947

Rx Quality Nutritional Preparations for the Physician's Prescription...

All prescriptions bearing the recognized name of "Borden" (pioneers in the field of nutrition) conform to the highest standards of biologic requirements, and are subject at all times to the most rigid controls of quality and purity.

for infants

BIOLAC — *a complete food* (when vitamin C only is added) — a contribution to optimum nutrition, because of high-protein, low fat, and added lactose content — reinforced with vitamins A, B_1, B_2 and D, and iron.

DRYCO — the *high protein food,* with intermediate carbohydrate content for formula flexibility, and low fat content — quickly soluble in cold or warm water.

for adults

GERILAC — a *powdered modified milk* for special dietary uses. A rich source of essential nutritive elements for pre- and postoperative cases, convalescence, pregnancy and lactation, soft and liquid diets, and for the aged. Palatable and easily digested; *only water required for dilution.*

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MULL-SOY — for your patients allergic to milk — a hypoallergenic soy concentrate with essential nutritional values of cow's milk; easily digestible, palatable, well-tolerated.

BETA LACTOSE — *milk's natural carbohydrate,* exceptionally palatable, highly soluble — for formula modification for infants, and corrective therapy in constipation in adults.

KLIM* — *spray-dried whole milk with soft curd properties,* invaluable when availability or safety of fresh milk is uncertain — readily soluble in cold or warm water. For infant feeding, and for peptic ulcer and other special adult diets.

**The nutritional statements of this advertisement are acceptable to the Council on Foods and Nutrition of the A.M.A.*

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Borden's PRESCRIPTION PRODUCTS DIVISION

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THE NATIONAL BLOOD PROGRAM

of the

AMERICAN NATIONAL RED CROSS

On June 12, 1947, the new Board of Governors, American National Red Cross, meeting in Cleveland, Ohio, ratified and confirmed a previous action of the Central Committee approving and authorizing the National Blood Program as an activity of the American National Red Cross. By this decision they brought to a climax several years of intensive study and consideration of what the American National Red Cross might do to help supply blood needed to safeguard the health of all the people of the nation and to be the means of saving the lives of untold thousands.

THIS ACTION insures to peacetime the gains to humanity of the record in life saving that had never been equaled before in times of war. It recognizes that the lessons learned since the dropping of the atomic bombs on Hiroshima and Nagasaki call for broad national planning to meet the future needs of national defense, both military and civilian.

There are five important operations in connection with a national blood program:

(1) collecting the blood

(2) processing it for use as whole blood and blood derivatives, including packing and storage

(3) distributing the blood and blood products for the needs of the people

(4) making blood available for continuous research and investigation to insure safety of the products and to determine the uses to which they may be put for the greatest benefits of mankind

(5) maintaining of high standards set by the leading authorities in this field.

A program of such magnitude must of necessity be one of gradual development. Time will be required to organize the work, to procure and train the personnel, and to obtain equipment which is in short supply. The first year of operation contemplates the establishment of 20 or 25 centers carefully selected with relation to the advantages they offer in the early stages. It is estimated that from three to five years will be required before the program is in full operation. In the meantime local programs will continue on their present basis, and new programs will be established as heretofore with the expectation of integration with the national program later on. In this way, full benefits from the fractionation phase of the program will be available to those communities where only whole blood and plasma are now being provided.

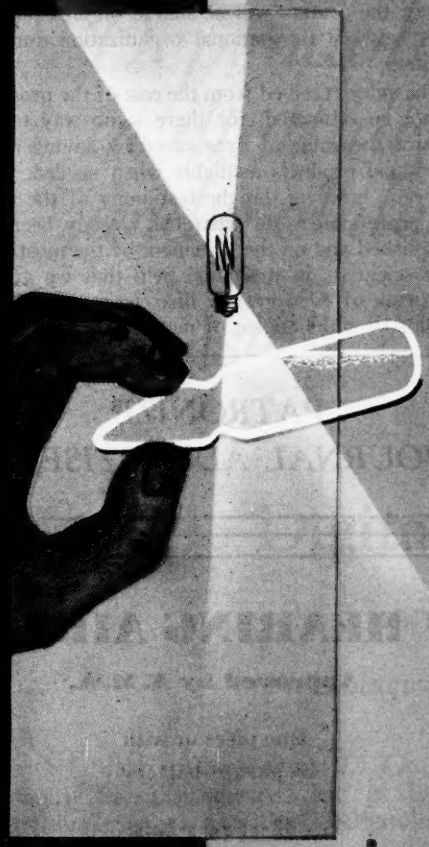
In addition to whole blood and plasma, the National Blood Program will provide other blood derivatives of proved value: serum albumin, used for shock and certain kidney diseases and other conditions; immune serum globulin, for modification or prevention of measles; antihemophilic globulin, effective in the treatment of hemophiliacs, or "bleeders", blood grouping serum, for determining blood types; fibrin films, used in brain and nerve surgery; red cell suspensions, for treating certain anemic conditions; and red cell paste and powder, to promote the healing of certain wounds. Any other products which continuing research may find useful in medicine and surgery will be provided.

Since people in rural districts require blood as well as those in cities the program must be sufficiently flexible to meet widely varying conditions and needs in large and small communities throughout the country. It is the ultimate goal to collect blood from volunteers from every community everywhere and to give every healthy person an opportunity to make a contribution at least once a year. For those people to whom a blood donor center is not available it is planned to provide the services of a mobile unit.

Under certain conditions it may be expedient to type the donors in a community and have them available when whole blood is needed in an emergency situation. In other instances plasma or serum albumin and other stable derivatives will be made available and will tide cases over until whole blood can be transported from a central depot where all types are constantly on hand. In this way the program will be enabled to fulfill its purpose to furnish blood, blood plasma, and all of its derivatives to all the people of this country irrespective of race, creed, color or financial ability to pay. The only charge ever made to any patient will be a reasonable one by the physician or hospital for professional services in administering the material. The Red Cross will make no charge.

continued on page 618

Hold it up to the Light!



A life may depend on the purity and clarity of the urographic contrast medium to be injected intravenously. NEO-IOPAX, a superior solution for intravenous pyelography, is triple checked through every stage of its preparation for exact composition and sterility, and then inspected repeatedly for the presence of extraneous foreign matter.

Neo-Iopax

disodium N-methyl-3,5-diiodo-chelidamate

Hold your contrast medium up to the light before injecting it. You will find NEO-IOPAX solutions sparkling and crystal clear—a good index of the care with which they have been processed. Naturally, we take pride in the NEO-IOPAX safety record, based on hundreds of thousands of injections.

NEO-IOPAX, stable solution of disodium N-methyl-3,5-diiodo-chelidamate, is available in *water-clear glass ampules only*, in 50 and 75% concentrations.

Trade-Mark NEO-IOPAX—Reg. U.S. Pat. Off.

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RED CROSS BLOOD PROGRAM

concluded from page 616

That part of the program which deals with collecting blood will operate substantially along the same lines as the wartime blood program, with established blood donor centers, and with mobile units to cover outlying communities. Red Cross chapters will assume the important responsibility of complete community organization to enroll blood donors and will arrange for the bleedings as needs require. In addition to the competent professional personnel for technical work, many volunteers will be necessary for nontechnical work in the centers.

That part of the program which deals with processing of the blood will involve highly skilled work. Some of the blood collected will be examined, typed, and distributed to local hospitals for use as whole blood; some of it will be shipped to commercial laboratories with which contracts will be made by national headquarters to fractionate blood into its derivatives. It is believed that approximately 60 percent of the blood collected will be used as whole blood.

That part of the program which deals with distribution involves making the best possible arrangements that will afford ready accessibility of the blood and blood products to all people and their physicians and hospitals, including veterans, military, and marine as well as civilian hospitals.

That part of the program which deals with continuous research and study as to the effectiveness and new uses of the blood products will be carried on by research authorities with the guidance of the Blood and Blood Derivatives Committee of the American National Red Cross Advisory Board on Health Services.

Inasmuch as, on the basis of recorded scientific and medical opinion, there is no difference in the blood of humans based upon race or color, the plan does not require the segregation of blood; however, whenever necessary to insure the success of the plan, which is to make available blood and blood derivatives to all the people of the United States regardless of race or color, chapters will collect and hold blood in such a manner as to give the physician and the patient the right of selection at the time of administration.

Operating centers of the National Blood Program will be selected and established only after full consultation between the national organization and the chapters concerned. Such chapters will be furnished with complete and detailed information covering the method of organization of the chapter blood donor service, ground work for community support, public relations and promotion, the use of publicity, suggested publicity aids, the operation of the blood donor center, clinic instructions, and the relationships between chapters, area, and national headquarters.

The program will be financed through contributions made by the American people. Each year the Red Cross fund campaign will take into consideration the amount necessary to carry on this important new service.

The cost for the first year may be between three million and five million dollars. The costs of operation of the centers will be shared on an equitable basis between the national organization and the chapters.

The value received from the cost of the program cannot be estimated, for there is no way to determine the value of lives saved by having blood and blood products available when needed. One can rely, however, on the testimony of the medical profession as to what has already been accomplished and on the statement of the most eminent scientists in the blood field that we are on the brink of even greater discoveries in the uses of blood for the benefit of mankind.

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held at 7 p.m. Wednesday, June 4, 1947, at the Pawtucket Golf Club. This was the annual Sports Day and the golf tournament was held during the afternoon.

The meeting was called to order by the President, Dr. Earl J. Mara. As there was no new business or unfinished business a motion was made by Dr. William Kalcounos that the business meeting be adjourned until September. This motion was seconded by Dr. Albert Gaudet and passed.

Dr. Mara turned the meeting over to Dr. Earl Kelly, who presided as Master of Ceremonies. The following golf prizes were awarded.

First prize, Dr. Albert Gaudet; Second prize, Dr. Henry Turner; Winner of Putting Contest, Dr. Harry Hecker.

Door prizes were awarded to the following: Doctors Earl Mara, Orland Smith, J. Lincoln Turner, Alfred Boucher, Albert Gaudet, William Kalcounos, Charles Farrell.

Following these awards, Dr. Kelly introduced "Professor" Arthur Dooley whose anecdotes drew the usual hilarious response from all present.

The meeting adjourned at 9 p.m.

Twenty members attended.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D.
Secretary

THROUGH . . .  *the Microscope*

The Mayo Memorial As a tribute to Doctors William J. and Charles H. Mayo the Minnesota legislature in 1945 approved a grant of $750,000 on the condition that an equal amount be given privately for the construction of a Mayo Memorial building. This structure is to be planned as the nucleus of a medical center at the University of Minnesota devoted to the search for medical knowledge, the training of physicians, and the care of the sick. So far some three thousand corporations and individuals have contributed $1,160,000.

However, the rising cost of labor and materials halted the plans, and an additional $750,000 grant had to be forthcoming from the legislature this year, given with the same condition as the previous one. With but a quarter of a million in public subscription needed to match the State grants, the memorial fund should soon reach the three million mark to permit the construction to get under way.

Funds for Hospitals A citizens' conference on hospital capital needs of Philadelphia and vicinity met last month to make a new approach to the problem of raising funds. As a board of directors 57 Philadelphians—physicians, hospital administrators and laymen—were elected to explore and to determine whether the needs can best be met by a unified money-raising drive or by independent campaigns. Remarks from the floor during the conference indicated that there was strong support for the joint fund campaign.

Money raising at any time is not an easy task, whatever the cause for which the funds are to be used. Hospitals may be community enterprises, but each tends over a period of years to develop an individuality that affects the community population in various ways. Hence a united appeal for financial aid for all hospitals, on the surface an apparently simple way in which to create one sizable fund, is fraught with the difficulties that stem from the allocation to the individual institutions.

We have been fortunate in Rhode Island that the public has responded willing to the many appeals for help. In the Providence metropolitan area the campaigns for Rhode Island and Miriam hospitals have been well supported, while elsewhere in the state the communities of Pawtucket and Woonsocket have generously responded to the appeal for aid for the local hospitals. But for a long term plan to guarantee assistance for all the hospitals to meet necessary expansions or operating deficits the suggestion of a United Hospital Campaign may well warrant study.

Cancer Control Program With Congress more than tripling appropriations for research and control of cancer, bringing next year's budget for the National Cancer Institute to the all-time high of $14 million, the United States Public Health Service has announced plans for an expanded attack on the cancer problem that will place the disease in the forefront of the Government's medical research and control programs.

Under the broad authority provided in the Public Health Service Law and the Appropriations Act, support may now be extended to universities to assist them in developing greatly expanded cancer research and training programs. Already a total of forty-six project grants have been made to widely scattered groups.

Four million dollars of the budget has been allocated to cancer control with the program to be administered through the States to increase the effective use of present methods of diagnosing and treating cancer. This program will place emphasis on the improvement of cancer detection, diagnostic and treatment facilities; the development of refresher courses for doctors; the establishment of adequate statistical services on cancer; and the setting up of cancer control units in State Health Departments.

continued on page 624

FORMULAC Infant Food provides a balanced and flexible formula basis for general infant feeding — both in normal and difficult diet cases.

A product of National Dairy research, FORMULAC is a concentrated milk in liquid form, fortified with all vitamins known to be necessary for proper infant nutrition. No supplementary vitamin administration is necessary with FORMULAC. The Vitamin C content is stabilized, assuring greater safety.

The only carbohydrate in FORMULAC is the natural lactose found in cow's milk—no other carbohydrate has been added. This permits you to prescribe both the amount and the type of carbohydrate supplementation required.

FORMULAC is promoted ethically, to the medical profession only. Clinical testing has proved it satisfactory in promoting normal infant growth and development. On sale in grocery and drug stores throughout the country, FORMULAC is priced within range of even modest incomes.

***Distributed by* KRAFT FOODS COMPANY**

NATIONAL DAIRY PRODUCTS COMPANY, INC.

NEW YORK, N. Y.

• For further information about FORMULAC, and for professional samples, mail a card to National Dairy Products Company, Inc., 230 Park Avenue, New York 17, N. Y.

THROUGH THE MICROSCOPE

continued from page 622

Physical Medicine The recent annual report of the Baruch Committee on Physical Medicine — a committee organized in 1944 with a grant of one and one quarter million dollars — forecast increased opportunities in rehabilitation for the 23 million Americans disabled by accident, disease, maladjustment and war. The advancements in physical medicine and rehabilitation in the period covered by the report were termed of real significance in medical history by the leading physicians and medical educators who compose the Committee. Particular emphasis was laid on research in the science of hydrology, the therapeutic use of water, a field in which Mr. Baruch's father, Dr. Simon Baruch, as the first professor of hydrology at Columbia University, was one of the original pioneers.

The Cost of Medical Education The Bulletin of the Columbus (Ohio) *Academy of Medicine* editorialized last month on the scant publicity given to the ever increasing cost of education for the physician who is to administer medical care in this country. Citing a recent survey of 50 approved medical schools, the editorial pointed out the average medical student pays out more than $7,000 for four years of medical education. This sum does not include four years of pre-medical training and the so-called fifth year of internship. Then, too, the modern trend of having all interns qualify before a specialty board for certification adds three more non-profitable years to the total school years.

Thus, cites the editorial, before the present day physician sees his first private patient he has expended $7,500 for pre-medical education, $7,500 for medical training, one year as an intern with no salary ,and three years residency at a minimum salary in order to be certified by a board. A conservative estimate, the editorial writer concludes, of the cost of education and the earning loss while in school would be $30,000.

Greatest Medical Center Underway What is planned to be the greatest medical research center in the world will be built at Forest Glen, Maryland, by the Corps of Engineers for the Office of the Surgeon General, according to a recent announcement. In keeping with technological advances in all fields, based on experiences in the late war, the center will be equipped to anticipate and meet the medical problems of the future as well as to cope with those of the present. With the initial cost set at $40 million the project will consist of a 1,000 bed general hospital, the Army Institute of Pathology building, the Army Medical Museum and center administration building, the central laboratory group buildings, and the Army Institute of Medicine and Surgery.

continued on page 626

The subject is: **Allergy**

The advice, as usual, is:
"SEE YOUR DOCTOR"

In LIFE and other national magazines, Parke-Davis presents a timely message about allergy (shown below). It appears in full color . . . reaches an audience of nearly 23 million people. It is No. 206 in the "See Your Doctor" series published in behalf of the medical profession.

Some things you should know about allergy

No. 206 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

MEDICAL science has discovered many interesting things about allergy.

If today you tell your doctor that you suffer from asthma, sneezing attacks, or itching eyes, one thing he considers is the possibility that you may be *allergic*—which means that you may be sensitive to some substance which causes no trouble for most people.

In discovering this offending substance (known as an allergen), your doctor acts as a detective. He may ask detailed questions about the time of your attacks, where they occur, the furnishings of your home, the food you eat.

Such questions may give him clues to the nature of your trouble. If your attacks come, for instance, in the late spring or summer months and last till the first frosts, he will suspect that your trouble is due to some pollen, that you may have some form of "hay fever."

In other forms of allergy, it is not so easy to track down the offending substance. If your case is not clear-cut, your doctor must consider hundreds of possibilities.

A few grains of mustard can make some people violently ill. A man can be sensitive to his wife's face powder, or to dog hair, or grass pollen, or to the cattle hair in the mat under a rug.

Simple skin tests are often used to reveal the offending substance. Drops of various extracts—of pollen, foods, and other substances—are injected into the skin or put on skin scratches. If you are sensitive to the substance being tested, a swelling will usually develop within a few minutes.

Once a doctor has found what causes the allergic reaction—by means of the history of the case supplemented by skin tests—he will prescribe treatment according to the nature of the patient's sensitivities.

If the patient is allergic to a particular food, the easiest solution is to avoid the food. If his sensitivity is to feathers, the substitution of a fibre pillow for a feather one may bring surprisingly effective relief.

If the allergen is house dust or pollen, or something else that cannot be easily avoided, a series of inoculations may be suggested.

Some people, however, do not respond to this type of treatment, or are sensitive to too many different things to make inoculations a practical procedure. New chemical drugs—developed to control allergic reactions in certain types of allergy—are showing promise. They are to be used, of course, only under the direction of a physician.

SEE YOUR DOCTOR. If you suffer from recurring and unexplained attacks of sneezing, skin rashes, or asthma, see your doctor. In allergy, as in other medical problems, your physician can give you more help today than ever before.

Makers of medicines prescribed by physicians

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The Birth Rate Although the birth rate of 26.4 per 1,000 population including the armed forces overseas for the five month period, January to May, 1947, was nearly 40% higher than the provisional rate of 19.1 for the corresponding period of 1946, the birth rate has been lower this year than it was in the last four months of 1946 when it reached record breaking heights. The decrease has taken place in spite of the fact that marriages in 1946 increased about 680,000, or 42%, over the 1945 total of nearly 1,620,000. The estimated marriage rate per 1,000 of the population (excluding armed forces overseas) stood at 16.4 in 1946 compared with 12.3 in 1945.

Frequency Bands for Medical Diathermy Equipment The Secretary of the American Medical Association reported recently that Medical diathermy equipment may be operated on the 13.66 megacycle, 27.32 megacycle and 40.98 megacycle bands without license, according to Public Notice No. 7722 of May 9, 1947, released by the Federal Communications Commission. No limit is given to the power output that may be radiated. Diathermy apparatus operated outside the assigned frequency bands above shall be completely shielded and filters placed in the power line. The Commission will determine if the diathermy equipment is not operating in compliance with the rules and in such cases will notify the owner, who is responsible for making the changes to prevent interference.

All equipment manufactured before July 1, 1947, will *not* be subject to the new regulation for a period of 5 years (June 15, 1952).

A special band at 2450 megacycles has been made available for industrial, scientific and medical purposes. This is to allow the production of experimental machines of extremely short wave length —approximately 12 centimeters long. Such machines have not been used by the medical profession up to the present time. However, this channel may be subject to development in later years as the medical profession either accepts it or not.

Your Doctors—1947 The headquarters staff of A.M.A. recently reviewed the latest March of Time Film "Your Doctors—1947." With the possible exception of overemphasis on psychosomatic medicine and specialization, the film is good. Principle locale is New York (New York Academy of Medicine and Mt. Sinai Hospital) with a few shots of the Lahey Clinic in Boston. The film shows a brain operation; the use of the artificial kidney; an RH transfusion performed on a new baby, and the use

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of atomic isotopes in treating cancer of the thyroid. On the psychiatric side, the shots of the young child deprived of its mother were particularly effective. The film will be shown in your neighborhood theatres shortly.

Obstetrics and Gynecology Our last report indicated that at least twenty physicians from Rhode Island will be among those in attendance at the third American Congress on Obstetrics and Gynecology when the session starts on September 8 at St. Louis. Aiming to hold a meeting that will be of value not only to the obstetric-gynecologic specialists but to those who come in contact with the greatest possible number of maternity cases—the general practitioners—the Congress promises to attract a sizable nationwide audience of physicians. Further information on the meeting may be secured by writing the Congress office at 24 West Ohio street, Chicago 10.

Public Relations The recent announcement by Boston University that it will inaugurate a course in public relations is the first attempt with which we are familiar to solve the riddle of what constitutes a public relations expert. The resignation in June of the Raymond T. Rich Associates (Rich is a Brown '22 alumnus) as public relations consultants to the American Medical Association has provoked much discussion of the whole field of medical public relations. Even our junior Senator has made quite an issue of the Rich incident in his statements to the Congressional committee studying the national compulsory health tax plan. But if Mr. McGrath thought the Rich report something to quote he should take time to evaluate the "profound research" (four days by one expert, and five by another) that resulted in feature sections on the state health department, and the state institutions, in the voluminous tax commission study in Rhode Island this past Spring. Our locally appointed voluntary commissions reported clearly and convincingly for years to Mr. McGrath and his predecessors in public office about needed improvements in welfare and health, but their recommendations have been filed away without action being taken.

Research Fellowships The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1948-June 30, 1949. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work.

The stipend will be from $2,200 to $3,000.

Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than November 1, 1947. Announcement of the awards will be made as promptly as is possible.

HOUSE OF DELEGATES

Next Meeting

MONDAY, SEPTEMBER 15 AT 8:30 P.M.